DOCUMENT RESUME

ED 394 623 PS 023 506

TITLE	The Progress of Nations: The Nations of the World Ranked According to Their Achievements in Child Health, Nutrition, Education, Family Planning, and Progress for Women, 1995.
INSTITUTION	United Nations Children's Fund, New York, N.Y.
REPORT NO	ISBN-92-806-3170-5
PUB DATE	95
NOTE	60p.; Photographs may not copy adequately. For 1994 edition, see ED 372 854.
PUB TYPE	Collected Works - Serials (022) -- Statistical Data (110)
JOURNAL CIT	Progress of Nations; 1995
EDRS PRICE	MF01/PC03 Plus Postage.
DESCRIPTORS	Child Abuse; *Child Health; Child Neglect; Children; *Childrens Rights; Child Welfare; Developed Nations; Developing Nations; Diseases; Equal Education; *Family Planning; *Females; Foreign Countries; Literacy; *Nutrition; Performance Factors; Poverty; Sex Fairness; Sexual Abuse
IDENTIFIERS	Foreign Aid; Maternal Health; Polio Vaccines; United Nations Convention on Rights of the Child

ABSTRACT

This report brings together the latest available statistics on national achievements in child survival, health, nutrition, education, family planning, and progress for women. Each section contains a commentary, a presentation of related statistics, and a discussion on achievement and disparity. The sections are: (1) Introduction, "Social Goals and Economic Reality" (Richard Jolly); (2) Health, "Ending Polio--Now or Never?" (Jong Wook Lee); (3) Nutrition, "A Bridge Too Near" (Alfred Sommer); (4) Education, "More of the Same Will Not Be Enough" (Victor Ordonez); (5) Family Planning, "A New Family Planning Ethos" (Judith Bruce and Anrudh Jain); (6) Child Rights, "A Conventional Approach" (Hoda Badran); (7) Progress for Women, "Discrimination Not the Problem" (Frene Ginwala); and (8) Aid, "A Shameful Condition" (Gro Harlem Brundtland). The report also includes a section, "National Performance Gaps," that provides additional statistical data on the progress of nations. This section presents the national performance gaps for all countries in child survival, nutrition, and primary education, along with a basic social profile of each nation and a list of social and development goals that have been adopted for 1995 and the year 2000. (MDM)

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THE PROGRESS OF NATIONS

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The nations of the world ranked according to their achievements in child health, nutrition, education, family planning, and progress for women

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** EDITORIAL ALERT....EDITORIAL ALERT....EDITORIAL ALERT **

Correction for page 35 of The Progress of Nations

With regard to the right-hand column of estimates on working children:

The figure for Mexico, of 11 million children under age 15 involved in economic activity, is invalid and should not be cited.

THE PROGRESS OF NATIONS

The day will come
when the progress of nations will be
judged not by their military or economic
strength, nor by the splendour of
their capital cities and public buildings,
but by the well-being of their peoples:
by their levels of health, nutrition and education;
by their opportunities to earn a fair reward for their
labours; by their ability to participate in the
decisions that affect their lives; by the respect that is
shown for their civil and political liberties;
by the provision that is made for those who are
vulnerable and disadvantaged; and by
the protection that is afforded to the growing minds
and bodies of their children.
The Progress of Nations, published annually
by the United Nations Children's Fund, is a
contribution towards that day.

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MIDDLE EAST and NORTH AFRICA

SOUTH ASIA

EAST ASIA and PACIFIC

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INDUSTRIALIZED COUNTRIES

COUNTRIES IN TRANSITION

I welcome *The Progress of Nations 1995* as a contribution to the cause of social development. This valuable publication records the practical progress being made by many States toward the goals that were established at the *World Summit for Children*, held at the United Nations in September, 1990. These impressive achievements are in large part the result of the commitments made on that occasion, and the subsequent sustained cooperation between Member States and the United Nations. In providing a detailed account of the deeds that have followed words, these pages provide an effective response to those who rightly ask for practical results from the convening of conferences and the setting of goals. They also show an aspect of the developing world – and of the work of the United Nations – which both needs and deserves wider acknowledgement.

Boutros Boutros-Ghali
Secretary-General of the United Nations

This is the third year in which UNICEF has issued this important document. It sets out for all to see the progress being made for children and women, in all regions of the world. Part of the record shows progress country by country, in relation to the goals agreed at the World Summit for Children held at the United Nations in 1990. Part relates to progress or set-backs in other areas of concern for child survival, protection and development. All is provided by UNICEF as a stimulus to us all – countries and communities, individuals and international organizations – to make the world a better place for all the world's children.

May I thank Peter Adamson, editor of *The Progress of Nations*, and his colleagues for once again providing UNICEF with a publication which brings into such sharp focus the advances and the set-backs in this struggle.

Carol Bellamy
Executive Director, UNICEF

Articles written by outside contributors represent the personal views of the authors and do not necessarily reflect UNICEF policy.

UNICEF House, 3 United Nations Plaza, New York, NY 10017, USA

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INTRODUCTION

Economic and social progress must walk together, or they will hold each other back

Social goals and economic reality

The Progress of Nations 1995 records the significant advances being made by many countries in health, nutrition, education, family planning, and progress for women. It reports, for example, the steep fall in the number of children being crippled by polio, and the gains being made against the handful of common diseases which, in alliance with poor nutrition, kill more than 7 million young children a year. It records, also, the quite spectacular advances being made against the micronutrient deficiencies which are among the major specific causes of death and disability for the children of the developing world. Other chapters chart the increase in schooling, the steady rise in the proportion of people with access to safe water, and the continued slowing down of birth rates in every region of the world.

Many of the achievements recorded in these pages are the result of conscious efforts to set and reach specific, time-bound targets. And though they are the product of sustained and often unacknowledged efforts by developing country governments, by United Nations agencies, and by thousands of non-governmental organizations, many of them owe a great deal to the inspiration of one man.

As Executive Director of UNICEF from 1980 until his death in January 1995, James P. Grant was a driving force behind the process of setting goals and mobilizing the political, social, and financial resources to achieve them. To catalyse this process he devised the 1990 World Summit for Children, which brought almost all the world's nations to a common agreement on social development goals to be achieved by the year 2000. Those goals are summarized on pages 52 and 53, and the progress being made towards them is recorded throughout this edition of *The Progress of Nations*.

Jim Grant believed that the struggle to set and achieve these specific targets was part and parcel of a historic struggle to improve the human condition. In the face of all the bad news which daily assaults our hope and optimism, he insisted on lifting our eyes from the headlines of the day to the horizons of our history. The last 50 years, he constantly reminded us, have seen average life expectancy in the developing nations rise from 40 to over 60 years, child death rates fall from 300 to 100 per 1000 births, and adult literacy rates double to 70%.

But it would be a mistake to confuse the optimism and determination that Jim Grant brought to this cause with the notion that such progress is in any way automatic, or that the social indicators that measure human well-being are on some kind of effortless and irresistible upward trajectory.

In particular, it would be a mistake to assume that progress can be accelerated by the exclusive pursuit of social goals in a deteriorating economic or physical environment, or that the worst aspects of poverty can be abolished without changing the unjust and exploitative economic relationships, between and within nations, which deny poor countries and poor people the chance to earn a fair return for their labours.

The Progress of Nations records the successes and failures of nation states in converting available resources into people's well-being. It is shot through with examples to show that economic performance is not everything, and that many poor nations are achieving levels of health, nutrition, and education that far surpass those of richer nations. The concept of the national performance gap systematizes these contrasts and comparisons in order to show how well each nation is performing in relation to the average for its level of per capita GNP (see pages 20, 32, and 50).

But evident as it is that some countries are extracting more social miles per economic gallon, the fact remains that economic and social progress must proceed side by side or they will eventually and inevitably hold each other back.

After the failure of 'trickle down' in the 60s, the frustrated hopes of a new economic order in the 70s, and the 'lost decade' of the 80s, much of the poor world is now reaching a crisis point in its struggle for economic development. Joblessness, landlessness, and increasingly desperate poverty have been allowed to set up the destructive synergisms of rapid population growth, increasing environmental pressures, rising social tensions, and political instabilities of a kind and on a scale which will eventually leave no community untouched. And unless national governments and the international community renew the quest for the new economic policies and relationships that will not only create growth but also ensure its more equitable distribution, then there is a clear danger that these pressures will overwhelm both past progress and future hopes.

Issues of trade and market access, commodity dependence and diversification, aid and investment, debt servicing and defence spending, land reform and labour-intensive increases in productivity still largely determine whether families have the kind of useful and remunerative work which enables them to meet their own needs by their own efforts and to build a stake in their own futures and in the stability of their societies.

Much of the responsibility for meeting this challenge lies with the established industrialized nations that still control three quarters of the world's wealth and dominate the structures of trade, aid, and finance within which the developing world must earn its living. So far the rich nations have not, in the main, taken this challenge very seriously. And it can only be hoped that the World Summit for Social Development held in Copenhagen in early 1995 might succeed, where many other conferences and commissions and reports have failed, in getting across the new urgency of the old struggle for economic development. Certainly there were enough responsible voices raised in Copenhagen to alert the industrialized nations to the fact that they are now playing in the last chance saloon of peaceful cooperative solutions to these problems.

No one today can seriously question the importance of conscious attempts to set and achieve measurable social development targets and to bring about specific improvements in the human condition. Such progress has not and will not come about as an automatic result of economic advance. But at the same time, the effort to achieve all that it is now possible to achieve in human health and well-being cannot ultimately succeed if it is pursued as an alternative to, or a distraction from, the fundamental problems of achieving sustainable economic growth and ensuring its more equitable distribution.

Richard Jolly,
Deputy Executive Director,
Programmes, UNICEF

HEALTH

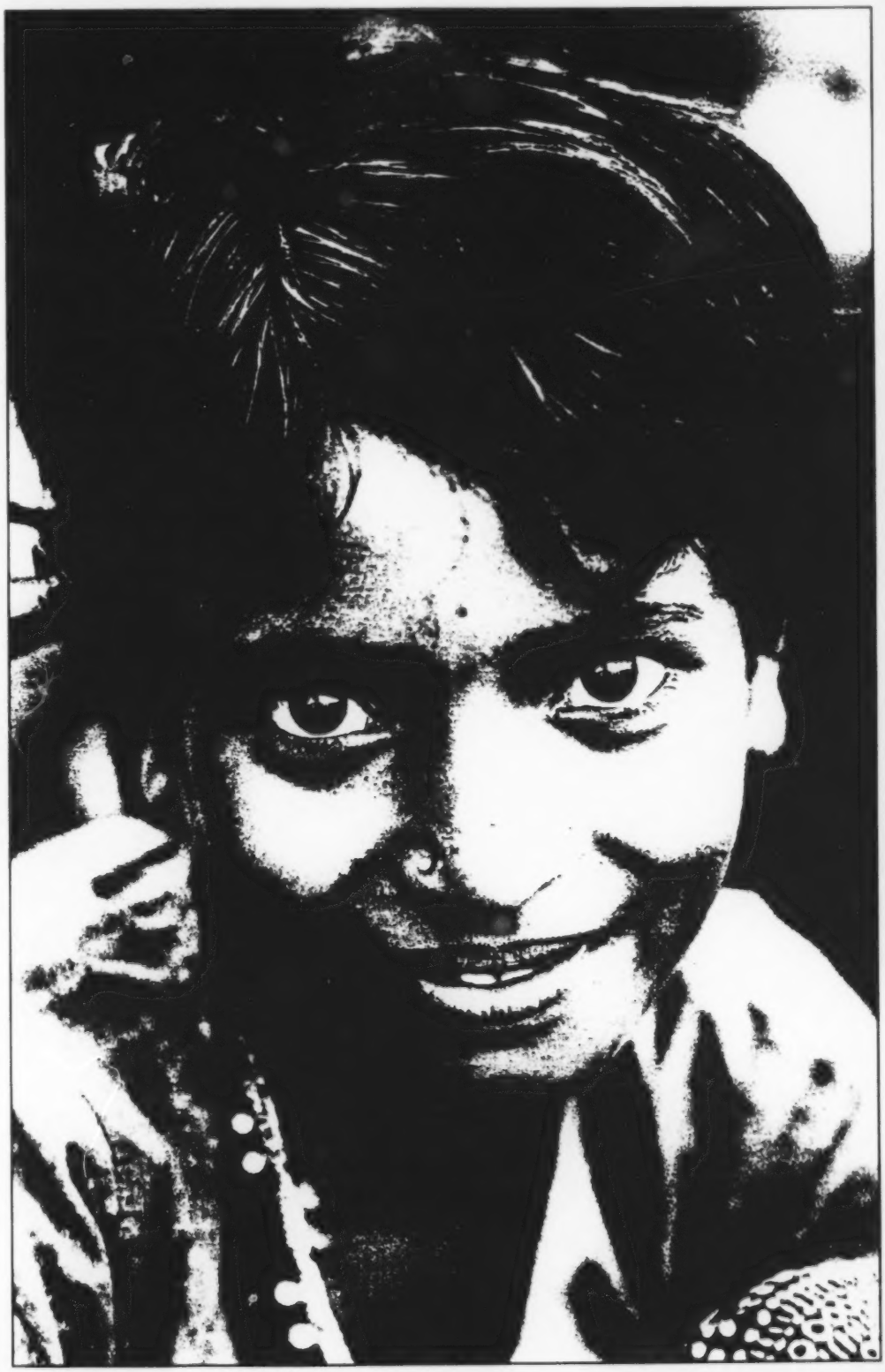
COMMENTARY

The number of polio victims worldwide is down by 75% in 10 years, and confidence is running high that polio will be eradicated by the target date of the year 2000.

But with polio reduced to low levels, many countries will find it difficult to justify spending the millions of dollars a year needed to finally wipe out the virus.

And it cannot be eradicated anywhere unless it is eradicated everywhere.

Jong Wook Lee argues that the steepest part of the road to polio eradication is yet to come.



Ending polio – now or never?

Jong Wook Lee

Dr. Jong Wook Lee is Director of the Global Programme for Vaccines and Immunization, WHO. Until 1994, he was Team Leader of the Polio Eradication Initiative in the Western Pacific Regional Office of WHO.

Under the impact of a 20-year effort, polio is in retreat. Worldwide, the estimated number of cases has fallen from 400,000 in 1980 to just over 100,000 in 1993. Of 213 countries under surveillance, 145 reported zero cases in 1993.

Confidence is therefore running high that the goal of eradicating polio by the year 2000 will be met.

Such confidence is dangerous.

Polio cannot be eradicated anywhere until it is eradicated everywhere. And as the following pages show, there are some 68 countries in which wild polio virus is still circulating. Some of those countries – Bangladesh, India, Pakistan – are among the largest and poorest. Others, like Ethiopia or Nigeria, have weak health infrastructure. One or two, like Myanmar, have not so far shown a real commitment to polio eradication. Still others, such as Azerbaijan and Uzbekistan, are witnessing new polio outbreaks as health systems deteriorate. And in many nations, from Afghanistan to Rwanda, the effort is being sabotaged by conflicts and their aftermath.

Adding to these difficulties, some of the donor nations are dragging their feet.

No hiding-place

Stage one on the road to eradication is a high level of routine coverage with oral polio vaccine (OPV). This reduces polio to low levels.

Stage two involves blitzing the virus in a series of national immunization days, during which all under-fives are given two doses of OPV. This immunizes those missed by routine coverage, and boosts the immunity of the already vaccinated. So far, 58 countries have held national immunization days. In 1994, for example, China reached 83 million children in just two days.

After this, the polio virus has few hiding-places (it cannot live for more than a few months without a human host). And the stage is now set for the final act.

Stage three demands a change in approach. Every suspected case of polio must now be detected by national surveillance systems backed by laboratories. If paralysis is found to be caused by wild polio virus (other viruses can mimic polio), then a supplementary immunization effort must be targeted to the outbreak.

In this way, the last hiding-places of the infection are discovered and eliminated.

If the effort to eradicate polio is to fail, then it will fail here at this final stage.

Large quantities of vaccine are needed and the surveillance systems, especially the laboratories, can be expensive. Meanwhile pneumonia, diarrhoeal disease, malaria, AIDS, are afflicting large numbers. Why should countries devote several million dollars to eradicating a virus which now affects only a handful of children a year?

No doubt people will say that the year 2000 is only a symbolic date, and that it doesn't really matter whether eradication is achieved in 2000, or 2005 or 2010. But this is an even more dangerous fallacy.

To see why, let us place ourselves at some date early in the next century. Polio has been almost but not quite eradicated. Very few cases are occurring. And it is now almost impossible for countries to continue devoting millions of dollars a year to the few remaining cases. The perceived threat has faded. And so has the political momentum. Donor countries cannot be persuaded to keep up the funding. With the momentum lost, even routine immunization levels may begin to fall.

Meanwhile the very low incidence of polio means an ever-increasing population of young people who are neither vaccinated nor immune through natural infection (most cases of polio are mild, with no long-term consequences).

In this way, the potential for a polio epidemic slowly builds up in the early years of the next century.

When that epidemic breaks it will be more difficult to cope with. The large pool of unprotected children will include older children (for whom polio is usually more serious), and efforts to surround outbreaks may then have to be aimed not just at under-fives but at the much larger group of under-tens or even under- fifteens.

Secondly, 'failure' will make it harder to mount another eradication attempt. Remember the effort to wipe out malaria? When it failed, mobilizing support for further attempts at malaria control became almost impossible.

Eradicating polio requires a head of steam. This we now have. But if the year 2000 target is not achieved, then that pressure will quickly be lost. We will have to start with cold water all over again.

It is therefore not a case of 'if not by the year 2000, then soon after'. Indeed, it may well be a case of 'now or never'.

Pioneering

The case for seizing the present opportunity to eradicate polio goes deeper than this. In particular, its cost-effectiveness needs to be weighed in a wider scale.

First of all, polio eradication is integrated into the worldwide vaccination programme, strengthening and being strengthened by the effort to build immunization systems. Second, it pioneers a path for bringing other major diseases under control, from measles to pneumonia. In the years ahead, there will be an increasing need to shift from 'input' approaches to 'outcome' approaches – from service coverage to ever more competent epidemiology. This requires different skills and strategies – which can be 'learned by doing' in the final stages of polio eradication.

More intangibly, eradication would boost morale. Success breeds success. And another famous victory would help to motivate the millions who wage the daily struggle for health throughout the world.

Economics

Finally, eradication makes obvious economic sense.

If the world remains in the limbo of the 'nearly but not quite' stage of polio eradication, then vaccination will have to be maintained in all countries. If eradication is achieved, all countries can cease vaccination.

Polio immunization costs about $270 million a year in the United States and about $200 million a year in Western Europe. The cost for the world as a whole is many times greater. The effort to eradicate polio would therefore pay for itself within a relatively short time – just as the eradication of smallpox has paid for itself many times over in the last two decades.

The last stage of this struggle will be difficult, particularly in countries affected by conflict. But it is reasonable to suggest that the industrialized nations should ensure funding. For it is to the industrialized nations that the greatest savings will accrue. The total amount of external aid needed over the final five years of this effort will be approximately $130 million a year. The United States alone will save twice that much every year once the virus is gone.

The savings to the developing countries will also be significant. Only in the short term, therefore, is polio eradication competing for scarce health resources. Once achieved, it will actually release resources for the struggle against other threats to human health.

Following the victory over smallpox in the 1970s, there is now no doubt that polio can become the second major disease to be banished from the earth. We have the technologies and the strategies. At the present time, we also have the momentum. And it would be a tragedy if it does not carry us through to a final victory over poliomyelitis.

HEALTH

LEAGUE TABLE OF

The nations of the world are listed here according to the progress they are making towards eradicating polio by the year 2000.

The first step is a high level of routine immunization. National immunization days can then push the virus to the edge of extinction. Thereafter, every single case of child paralysis must be investigated and – if proved to be polio – surrounded by another immunization blitz.

Polio virus cannot survive for more than a few months without a human host. By the year 2000, all doors should be locked against the virus.

SUB-SAHARAN AFRICA

Botswana	2
Congo	2
Lesotho	2
Malawi	2
Mauritius	2
South Africa	2
Zimbabwe	2
Guinea-Bissau	3
Kenya	3
Mozambique	3
Namibia	3
Senegal	3
Tanzania	3
Uganda	3
Zambia	3
Benin	4
Burkina Faso	4
Cameroon	4
Central African Rep.	4
Chad	4
Côte d'Ivoire	4
Gabon	4
Ghana	4
Guinea	4
Madagascar	4
Mali	4
Mauritania	4
Niger	4
Sierra Leone	4
Togo	4
Angola	5
Burundi	5
Eritrea	5
Ethiopia	5
Liberia	5
Nigeria	5
Rwanda	5
Somalia	5
Zaire	5

MIDDLE EAST and NORTH AFRICA

Jordan	2
Kuwait	2
Lebanon	2
Libya	2
Morocco	2
Oman	2
Syria	2
Tunisia	2
U. Arab Emirates	2
Algeria	3
Iran	3
Saudi Arabia	3
Egypt	4
Iraq	4
Turkey	4
Sudan	5
Yemen	5

SOUTH ASIA

Bhutan	2
Sri Lanka	3
Bangladesh	4
India	4
Nepal	4
Pakistan	4
Afghanistan	5

Countries ranked 1 to 5 according to progress towards polio eradication. ***See box below.***

What the rankings mean...

KEY

1 Countries ranked 1
Polio eradication certified.

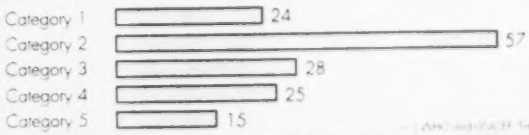
2 Countries ranked 2
Polio transmission probably ceased, but not certified.

3 Countries ranked 3
Low levels of wild polio virus transmission. Eradication could be achieved within a short time.

4 Countries ranked 4
Significant wild polio virus transmission (in some cases, lack of data).

5 Countries ranked 5
Eradication will be especially difficult (in many cases because health infrastructure is affected by armed conflict or civil strife).

Number of countries in each category



ACTION ON POLIO

EAST ASIA and PACIFIC

Hong Kong*	2
Korea, Dem.	2
Korea, Rep.	2
Malaysia	2
Mongolia	2
Papua New Guinea	2
Singapore	2
China	3
Lao Rep.	3
Philippines	3
Thailand	3
Viet Nam	3
Indonesia	4
Cambodia	5
Myanmar	5

LATIN AMERICA and CARIBBEAN

Argentina	1
Bolivia	1
Brazil	1
Chile	1
Colombia	1
Costa Rica	1
Cuba	1
Dominican Rep.	1
Ecuador	1
El Salvador	1
Guatemala	1
Haiti	1
Honduras	1
Jamaica	1
Mexico	1
Nicaragua	1
Panama	1
Paraguay	1
Peru	1
Trinidad/Tobago	1
Uruguay	1
Venezuela	1

INDUSTRIALIZED COUNTRIES

Canada	1
United States	1
Australia	2
Austria	2
Belgium	2
Denmark	2
Finland	2
France	2
Germany	2
Greece	2
Ireland	2
Israel	2
Italy	2
Japan	2
Netherlands	2
New Zealand	2
Norway	2
Portugal	2
Spain	2
Sweden	2
Switzerland	2
United Kingdom	2

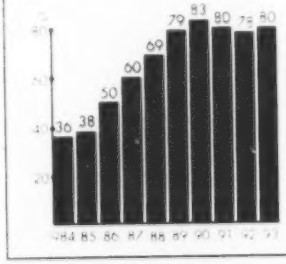
COUNTRIES IN TRANSITION

Albania	2
Bosnia/Herzegovina	2
Bulgaria	2
Croatia	2
Czech Rep.	2
Estonia	2
Hungary	2
Latvia	2
Lithuania	2
Macedonia**	2
Poland	2
Slovakia	2
Slovenia	2
Armenia	3
Belarus	3
Kazakhstan	3
Kyrgyzstan	3
Moldova	3
Romania	3
Russian Fed.	3
Tajikistan	3
Turkmenistan	3
Ukraine	3
Yugoslavia***	3
Azerbaijan	4
Uzbekistan	4
Georgia	5

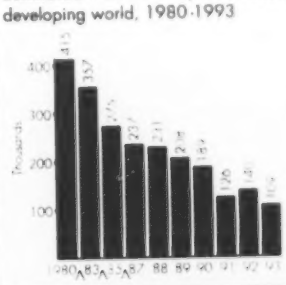
The rise of immunization and the fall of polio

The chart shows the results of the long struggle to reach the internationally agreed goal of 80% immunization by 1990. By the year 2000, there will be at least 5 million children under 10 who will be growing up normally but who would have been paralysed for life were it not for the effort to reach this goal.

Immunization up
% of under-ones immunized against polio, developing world, 1984-1993

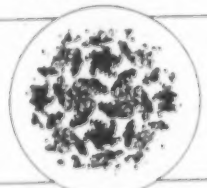


Polio down
Estimated number of polio cases, developing world, 1980-1993



Source: WHO and UNICEF, February 1995

THE POLIO VIRUS



Eradicated by the year 2000?

HEALTH ACHIEVEMENT AN

The effort to end polio is beating a path that could be followed by other disease eradication programmes.

For many nations, the next target will be measles – currently killing between 1 and 2 million young children every year and leaving many millions more in a weakened state.

An even more difficult challenge is pneumonia, which, with over 3 million victims a year, is now the biggest single killer of the world's children.

These pages report on national efforts against these two major threats to children's lives and health.

Sudan – three children in one family left permanently blinded by measles and malnutrition

Measles next?

Unlike polio, measles is not a word to strike fear into populations. In the industrialized world the disease is usually little more than a nuisance, and even in the developing world a majority of the children who contract measles recover with no apparent ill effects. But between 2% and 4% do not recover. And that means 1 to 2 million child deaths each year.

The tragedy does not stop there. Many of the survivors suffer from malnutrition and vitamin A deficiency, pushing up death rates in the year or so after a measles attack.

The good news is that measles could be the next major disease to be eradicated after polio.

Immunization of children against measles has risen from about 25% in 1980 to almost 80% today – an effort that is now preventing about 1.5 million child deaths a year.

But even high levels of routine immunization will not be enough. As with polio, national immunization days followed by the monitoring and blitzing of any outbreaks will be needed to eliminate the disease.

Latin America, the first region to eradicate polio, is also leading the way towards measles elimination. Most nations have held national immunization days, and the region as a whole aims to be clear by the year 2000.

Measles takes its heaviest toll in sub-Saharan Africa where only two nations, Malawi and Mauritius, have reached 90% immunization coverage.

Unlike the anti-polio effort, measles elimination has so far failed to attract the necessary political and financial support. In Indonesia, the 1994 national immunization day was scaled back to polio only because of lack of funds.

Ending measles is as feasible as ending polio. The strategy is clear and the low-cost technology is available. There is now no reason why a disease which has for so long been one of the main causes of death and malnutrition among the world's children should not be eliminated within a decade.

The 90% club

The following 45 nations have achieved 90% measles immunization. As the vaccine is not given until a child is at least nine months old, high levels of coverage among children under one demonstrate that an effective system of near-universal outreach has been established.

Measles immunization

	% immunized 1993		% immunized 1993
Dominican Rep	99	Colombia	94
Finland	99	Honduras	94
Hungary	99	Lithuania	94
Korea, Dem	99	Portugal	94
Romania	99	Ukraine	94
Cuba	98	Armenia	93
Czech Rep	98	Korea, Rep	93
Mauritius	98	Kuwait	93
Chile	97	Kyrgyzstan	93
Tajikistan	97	Mexico	93
Belarus	96	Viet Nam	93
Iran	96	Malawi	92
Israel	96	Moldova	92
Macedonia	96	Saudi Arabia	92
Norway	96	United Kingdom	92
Paraguay	96	Kazakhstan	91
Slovakia	96	Uzbekistan	91
Argentina	95	Croatia	90
Netherlands	95	Indonesia	90
Oman	95	Slovenia	90
Poland	95	Spain	90
Sweden	95	U.A. Emirates	90
China	94		

Poor who do better than rich

Per capita GNP below $1000, measles coverage 90% or more

	Per capita GNP ($) 1993	% immunized 1993
Korea, Dem	970	99
Tajikistan	470	97
Macedonia	780	96
China	490	94
Honduras	580	94
Viet Nam	170	93
Armenia	660	93
Kyrgyzstan	830	93
Malawi	220	92
Uzbekistan	960	91
Indonesia	730	90

Per capita GNP above $1500, measles coverage 70% or less

	Per capita GNP ($) 1993	% immunized 1993
Germany	23560	70*
Algeria	1650	69
Japan	31450	69
Lebanon	2150	65*
Gabon	4050	65
Venezuela	2840	63
Botswana	2590	60
Austria	23120	60
Italy	19620	50

DISPARITY

Lebanon – immunization up after violent years

Albania – 20-point drop

18 achieve 15-point rise

Eighteen nations have increased measles immunization by 15 percentage points or more between 1990 and 1993.

Spectacular increases have been achieved in two of the world's poorest countries – Guinea (up from 18% to 57%) and the Lao Republic (13% to 46%). Bolivia, South America's poorest nation, has achieved 81% measles coverage – up from just over 50% in 1990.

Among the most populous nations, Bangladesh stands out with an increase from 54% to 71% in just three years.

Eighteen countries have let measles immunization fall by more than 10 percentage points. Twelve of them are in sub-Saharan Africa, where it is proving difficult to sustain the massive immunization effort of the 1980s in the face of severe debt and adjustment problems.

Gabon, the richest country in sub-Saharan Africa, has allowed measles immunization to fall over 10 per cent in three years.

The steepest drop has been in Papua New Guinea where measles immunization has been more than halved.

Rising

Coverage 15 % points or more up

	1990	1993	% pt. rise
Guinea	18	57	39
Hong Kong	41	77	36
Lao Rep	13	46	33
Namibia	41	71	30
Bolivia	53	81	28
Paraguay	69	96	27
Lebanon	39	65	26
Iraq	62	87	25
Turkmenistan	63	84	21
Germany	50	70	20
Libya	70	89	19
Madagascar	33	52	19
Bangladesh	54	71	17
Kenya	59	76	17
Trinidad/Tobago	70	87	17
Mauritania	33	49	16
Mexico	78	93	15
U. Arab Emirates	75	90	15

Falling

Coverage over 10 % points down

	1990	1993	% pt. fall
Bulgaria	98	87	–11
Gabon	76	65	–11
C. African Rep	82	69	–13*
Chad	32	19	–13
Senegal	59	46	–13
Algeria	83	69	–14
Burundi	75	61	–14
Zambia	76	62	–14
Ethiopia	37	22	–15*
Panama	99	83	–16*
Liberia	55	38	–17
Botswana	78	60	–18
Albania	96	76	–20
Congo	75	55	–20
Nigeria	54	34	–20
Cameroon	56	34	–22
Bhutan	89	65	–24
Papua N. Guinea	67	31	–36

* Through national or local, the WHO Expanded Programme on Immunization has reported coverage in excess of 100% in some years. Ethiopia's 1990 and 1992 figures were 37% and 22%, Panama's 99% and 83%.

Only 21 nations go to scale against pneumonia

About half of all child deaths are caused by diarrhoea and pneumonia – often helped by malnutrition.

Most pneumonia deaths could be prevented by immunization, by parental awareness of the danger signs, and by antibiotics. Half the diarrhoeal deaths could be prevented by oral rehydration therapy (ORT) and continued feeding of the sick child.

The 1990 World Summit for Children established the goal of a one-third reduction in child deaths from acute respiratory infections (mostly pneumonia) and a halving of deaths from diarrhoeal disease.

The Progress of Nations 1994 reported that some 40% of diarrhoeal disease cases in children were being treated with ORT, saving an estimated 1 million lives a year.

The struggle against acute respiratory infections (ARI) is proving more difficult. WHO has developed guidelines to enable community health workers to diagnose pneumonia and to prescribe low-cost antibiotics. The strategies and the technologies are therefore available for reaching the year 2000 goal and preventing at least 1.5 million child deaths a year (pneumonia currently kills over 3 million children annually). The challenge now is to put known solutions into action on the same scale as the problem.

WHO wants to see ARI control programmes in all countries with infant death rates higher than 40 per 1000 births in 1989. The list below divides all such countries according to the progress being made.

Taking control

Progress towards ARI control programmes in countries with infant death rates higher than 40 per 1000 births in 1989

ARI control programme operational nationwide

Bhutan	Gambia	Jordan	Nicaragua	Zimbabwe
Bolivia	Guatemala	Mexico	Oman	
Botswana	Honduras	Mongolia	Paraguay	
Colombia	Iran	Myanmar	Philippines	
Egypt	Iraq	Namibia	Swaziland	

Control programme operational in part of the country

Afghanistan	Djibouti	Kenya	Nepal	Tunisia
Bangladesh	Dominican Rep	Lao Rep	Niger	Turkey
Brazil	Ecuador	Lesotho	Nigeria	Uganda
Cambodia	El Salvador	Madagascar	Pakistan	Viet Nam
Cameroon	Ethiopia	Malawi	Papua N. Guinea	Zambia
Cape Verde	Ghana	Maldives	Peru	
Chad	India	Morocco	Sierra Leone	
Côte d'Ivoire	Indonesia	Mozambique	Tanzania	

Plans drawn up – programme not yet active

Benin	Congo	Lebanon	Rwanda	Togo
Burundi	Gabon	Libya	Senegal	Yemen
C. African Rep	Guinea	Mali	Syria	

No national plan or programme

Algeria	Eq. Guinea	Liberia	Sao Tome/ Principe	South Africa
Angola	Guinea-Bissau	Mauritania	Saudi Arabia	Zaire
Burkina Faso	Guyana	St. Vincent/ Grenadines	Somalia	
Comoros	Haiti			

Source: WHO, unpublished data, December 1994

HEALTH

LEAGUE TABLE OF

The tables show what percentage of each country's population has access to clean water.

Because 'access' is defined differently by different countries, alphabetical order is used throughout.

The toll of disease could be drastically reduced by safe water, by using latrines, by washing hands before handling food, and by preparing and storing food safely.

Staying healthy is therefore easier for the rich than the poor.

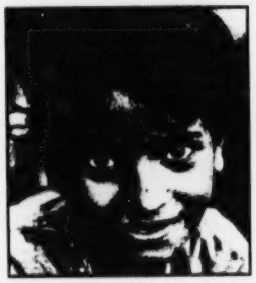
But even in poor communities, the potential for defending health is very much greater if clean water is readily available.

SUB-SAHARAN AFRICA

	%
Angola	32
Benin	50
Botswana	93
Burkina Faso	78
Burundi	70
Cameroon	50
Central African Rep.	18
Chad	24
Congo	OLD DATA
Côte d'Ivoire	72
Eritrea	16
Ethiopia	25
Gabon	OLD DATA
Ghana	56
Guinea	49
Guinea-Bissau	53
Kenya	53
Lesotho	52
Liberia	30
Madagascar	29
Malawi	47
Mali	37
Mauritania	81
Mauritius	99
Mozambique	32
Namibia	57
Niger	53
Nigeria	39
Rwanda*	66
Senegal	52
Sierra Leone	3
Somalia	OLD DATA
South Africa	70
Tanzania	50
Togo	63
Uganda	34
Zaire	27
Zambia	50
Zimbabwe	84

MIDDLE EAST and NORTH AFRICA

	%
Algeria	79
Egypt	80
Iran	83
Iraq	44
Jordan	89
Kuwait	NO DATA
Lebanon	100
Libya	OLD DATA
Morocco	55
Oman	63
Saudi Arabia	OLD DATA
Sudan	60
Syria	85
Tunisia	99
Turkey	80
U. Arab Emirates	95
Yemen	55



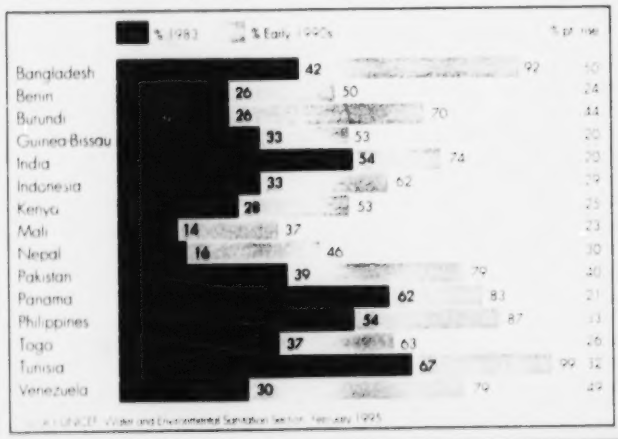
SOUTH ASIA

	%
Afghanistan	12
Bangladesh	92
Bhutan	21
India	74
Nepal	46
Pakistan	79
Sri Lanka	46

% of population with access to safe water (alphabetical order)

Running uphill

Based on their own criteria for access, 15 countries increased access to safe water by 20 percentage points or more between the early 1980s and 1990s – including five of the 'Asian giants'.



ACCESS TO WATER

EAST ASIA and PACIFIC

	%
Cambodia	36
China	69
Hong Kong	100
Indonesia	62
Korea, Dem.	NO DATA
Korea, Rep.	93
Lao Rep.	39
Malaysia	78
Mongolia	80
Myanmar	38
Papua New Guinea	28
Philippines	87
Singapore	OLD DATA
Thailand	86
Viet Nam	36

LATIN AMERICA and CARIBBEAN

	%
Argentina	71
Bolivia	62
Brazil	71
Chile	85
Colombia	87
Costa Rica	92
Cuba	93
Dominican Rep.	76
Ecuador	70
El Salvador	55
Guatemala	62
Haiti	28
Honduras	65
Jamaica	100
Mexico	83
Nicaragua	58
Panama	83
Paraguay	35
Peru	71
Trinidad/Tobago	97
Uruguay	OLD DATA
Venezuela	79

Guinea worm in retreat

Pakistan has become the first of the 19 countries struggling against guinea worm disease to report zero cases for a 12-month period. Over 1,000 cases were reported in 1988, a toll that was brought down to just 23 cases in 1992, 2 in 1993, and none in 1994.

In 1990, dracunculiasis, or guinea worm disease, was bringing pain, ulcers, fever, and joint deformities to approximately 3 million adults and children in Africa and Asia who were drinking infected water. At the 1990 World Summit for Children, the governments of all affected countries agreed to attempt its eradication by the end of 1995.

The table summarizes progress so far. The bottom line is that there were approximately 140,000 victims of guinea worm disease in 1994 – a reduction of well over 90%. Village-based activities to improve water supply, and enable people to protect themselves by filtering or straining unsafe water, have more than halved the number of villages where dracunculiasis is endemic – from about 23,000 at the start of 1993 to just over 10,000 at the beginning of 1995.

The year also brought fresh challenges. New endemic villages were discovered in Ethiopia and in 17 villages of Yemen. The first national search in the Sudan identified 28,900 cases.

Decline and fall

	Cases 1993	Cases 1994	% fall
Pakistan	2	0	100
Benin	16300	3400	79
Uganda	42900	10400	76
Senegal	800	200	75
Cameroon	72	22	69
Mali	12000	5400	55
Ghana	17900	8400	53
Nigeria	75800	35700	53
Togo	10300	5000	51
Chad	1200	600	50
India	800	400	50
Côte d'Ivoire	8000	5100	36
Burkina Faso	8300	6900	17
Mauritania	5900	5000	15
Niger	25300	23600	7
Kenya	35	37	-6
Ethiopia	1100	1300	See story
Sudan	3000	28900	See story
Yemen	–	74	See story
Total	229700	140400	39

Watery definition

Each nation sets its own definition of 'access' to water. In some countries it means piped water in each home, in others a well within half an hour's walk. Definitions also differ between urban and rural areas.

Countries are therefore listed on these pages in alphabetical order.

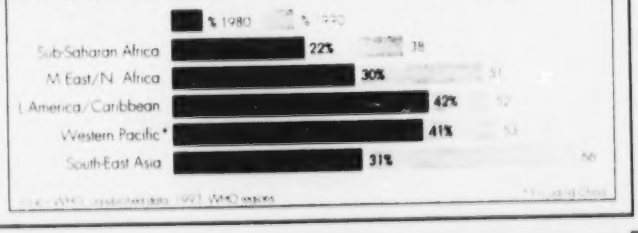
Improvements in health come not just from the availability of clean water but from its proper use. But proper use is more feasible if water comes from a standpipe close to home rather than a well half a mile away.

Millions of women spend many hours a day walking long distances for unreliable supplies of unsafe water. And as it is usually women who cope with family illness, improving access to safe water strikes a double blow for the liberation of women's time and energies.

Rise by region

Despite the difficulty of measuring progress, it is clear that extraordinary efforts have been made in many countries to improve access to safe water, and to involve local communities in the management of water supply.

Rural population with access to safe water, 1980 -1990



NUTRITION COMMENTARY

In the 1970s, researchers in Indonesia tracked 4,000 children over 18 months to find out more about the effects of vitamin A deficiency.

The lack of this particular vitamin has long been known to be the major cause of blindness among the world's children.

But unlooked-for and unseen amid the mass of data from Indonesia was a much more dramatic message.

As it begins to be acted on worldwide, that message promises to be one of this century's greatest specific breakthroughs for child health.

A bridge too near

Alfred Sommer

Dr. Alfred Sommer is Professor and Dean at the School of Hygiene and Public Health, Johns Hopkins University, Baltimore. He has been in the forefront of research into vitamin A deficiency for almost 20 years, and led the two major Indonesian studies described in this article.

For almost a decade, medical science ignored or rejected the evidence that vitamin A could reduce child deaths by between a quarter and a third in many countries of the developing world.

Today, the scepticism of the 1980s has been swept away by an avalanche of data. And as the tables on the following pages show, most nations are now moving to make this most cost-effective of all health interventions available to their children.

If this effort succeeds, then we can expect to bring about a fall in child deaths of somewhere between 1 million and 3 million per annum.

Discovered in 1913, vitamin A has taken almost a century to come into its own. It has long been known that the lack of this particular vitamin could cause stunting, infection, and blindness in animals. But it was 1974 before the first report was published (by WHO) on vitamin A deficiency as a major cause of blindness among the children of the developing world.

Missing the point

In that same year, a research project was launched in Indonesia to find out more about vitamin A deficiency, and particularly about what levels of deficiency were associated with xerophthalmia (the inflammation and drying of the eye that can result in permanent blindness). Over a period of a year and a half, 4,000 children were examined at three-month intervals.

By 1981 much useful information had been gleaned. But in looking only for what we expected to see, we had missed what the data itself had revealed. Unlooked-for and unseen amid the mass of figures was a much more dramatic message.

One December evening almost a year later, while a particular set of figures was being cross-tabulated, it became apparent that many xerophthalmic children were missing from later cross-tabulations. Running the computer analysis in the reverse direction revealed what the data had been waiting to tell us all along: children with even mild xerophthalmia were dying at a far greater rate.

Any suggestion that the higher death rate was caused by malnutrition, of which the lack of vitamin A was merely a symptom, was quickly dispelled. Malnutrition clearly increases the risk of child death, but so does vitamin A deficiency – even among adequately nourished children. In fact the Indonesian study showed that malnourished children with adequate vitamin A were less likely to die than well-nourished children who were deficient in vitamin A.

Preliminary calculations, soon to be revised upwards, showed that if xerophthalmia could be prevented, then the death rate among children aged one to six would fall by approximately 20%. Analysis also showed that the risk of death was directly related to the degree of deficiency.

To test these extraordinary conclusions, a second Indonesian study was launched. This time, vitamin A capsules were given every six months to approximately 20,000 young children in 450 randomly chosen villages. The result was a one-third reduction in death rates, compared with villages where there had been no intervention.

These findings were published in *The Lancet* and other medical journals. The response was the long silence of disbelief.

With its vision fixed on the high-tech and high-cost frontiers of modern medical care, the medical and research establishment found it difficult to accept that something as simple and cheap as a 2-cent capsule of vitamin A could represent such a breakthrough for human life and health. Perhaps in some quarters, also, there was an innate and ideological dislike of 'magic bullet' solutions to health problems which do not directly address the underlying problems of poverty.

Whatever the reason, a discovery that seemed to promise so much had caused barely a ripple on the surface of medical interest.

It was at this point that a wise colleague pointed out that this was the normal first reaction to any unexpected research finding. The next stage, he advised, was to "bury them in data."

Knowing that measles often leads to vitamin A loss, we had begun to wonder if Africa's high death rates from measles might also be connected with vitamin A deficiency. To test this, children hospitalized with measles in Tanzania were given vitamin A capsules. The measles death rate fell by half. It was at this point that we discovered, to our astonishment, that a similar experiment had been conducted 50 years earlier in a London hospital – with the same results: medicine too has doors it did not enter, paths it did not take.

WHO and UNICEF now acted quickly to make vitamin A supplementation a routine part of measles treatment. More broadly, the elimination of the deficiency became one of the goals adopted by the World Summit for Children held at UNICEF's instigation in the fall of 1990. The progress being made towards that goal is shown in the following tables.

By 1992, the results were in from several large, community-based investigations into vitamin A deficiency. Ghana, India, Indonesia, and Nepal all yielded results in line with the one-third reduction in mortality rates revealed by the original research in Indonesia.

At this point, the medical community accepted our conclusions as unanimously as it had dismissed them a decade earlier. A colleague who had earlier written a leader in *The New England Journal of Medicine* titled 'Too good to be true', now published a paper under the heading 'Too good not to be true'.

With the scientific community in full agreement, ministries of health across the world have now given the green light to vitamin A supplementation. Unfortunately, official recommendations usually stress vitamin A supplementation only where there is evidence of severe deficiency, whereas the evidence suggests that supplementation can significantly reduce mortality even among populations with mild vitamin A deficiency. Further studies are now needed to quantify this effect.

Three ways

Increasing vitamin A intake can be achieved by three main methods – improving diets, fortifying common foods, and distributing vitamin A capsules.

The politically correct method is dietary improvement through the addition of green leafy vegetables or carrots. Of course diets should be improved. But this is a slow and uncertain process, and there are doubts about whether it can provide sufficient vitamin A even where dietary change is indeed achieved. Certainly, more work is needed on the most effective dietary ways of beating vitamin A deficiency.

Some countries, particularly in Central America, have fortified sugar with vitamin A (the problem was solved in the industrialized world by adding vitamin A to common foods such as milk, bread, and margarine). But in the developing world as a whole, food fortification is only beginning to be explored.

In the meantime, at least two children are dying every minute for the lack of the protection that vitamin A can bring.

The 2-cent capsules are therefore an essential weapon for the defence of children. And the outreach systems which have been built or strengthened by the immunization effort of the last decade have now made it possible to deliver that protection to the great majority of children at risk.

There can be no excuse for further delay.

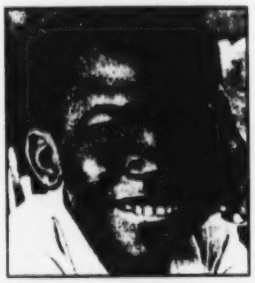
NUTRITION

LEAGUE TABLE OF

All nations are ranked here according to the progress they are making towards the internationally agreed goal of adequate vitamin A intake for at least 80% of children under two by the end of 1995 (in populations known to be at risk).

Over 200 million children worldwide are affected. Severe deficiency causes blindness and death. Less severe deficiency impairs immune systems, making common diseases more likely to be fatal.

The solution – improving diets, fortifying foods, or distributing vitamin A capsules – is available and affordable.



SUB-SAHARAN AFRICA

Botswana	1
Cameroon	1
Malawi	1
Zambia	1
Angola	2
Benin	2
Burkina Faso	2
Burundi	2
Ethiopia	2
Liberia	2
Madagascar	2
Niger	2
Rwanda	2
Uganda	2
C. African Rep.	3
Chad	3
Côte d'Ivoire	3
Eritrea	3
Ghana	3
Guinea	3
Guinea-Bissau	3
Kenya	3
Lesotho	3
Mali	3
Mauritania	3
Mauritius	3
Mozambique	3
Namibia	3
Nigeria	3
Senegal	3
Sierra Leone	3
Somalia	3
South Africa	3
Tanzania	3
Togo	3
Zaire	3
Congo	4
Gabon	4

MIDDLE EAST and NORTH AFRICA

Sudan	2
Egypt	3
Iran	3
Iraq	3
Lebanon	3
Oman	3
Syria	3
Turkey	3
Yemen	3
Algeria	4
Kuwait	4
Libya	4
Morocco	4

SOUTH ASIA

Bangladesh	1
India	1
Nepal	1
Pakistan	1
Afghanistan	2
Bhutan	2
Sri Lanka	2

Countries ranked 1 to 4 according to progress against vitamin A deficiency. See box below.

What the rankings mean... **KEY**

1 Countries ranked 1
Vitamin A deficiency exists as public health problem. Large-scale programmes under way. Country on target to reach 1995 goal of adequate vitamin A for at least 80% of children under two. Several countries, including Indonesia, Thailand, and Viet Nam have virtually eliminated severe vitamin A deficiency.

2 Countries ranked 2
Vitamin A deficiency exists as public health problem. Programmes being implemented. Present coverage inadequate. Significant acceleration required to reach 1995 goal.

3 Countries ranked 3
Vitamin A deficiency exists, or is likely to exist, as public health problem. No large-scale action being taken. Detailed assessment and/or programme planned for 1995 or 1996.

4 Countries ranked 4
No information available on vitamin A status of children.

Source: UNICEF field offices, February 1995

ACTION ON VITAMIN A

EAST ASIA and PACIFIC

Indonesia	1
Philippines	1
Thailand	1
Viet Nam	1
Cambodia	2
Myanmar	2
China	3
Lao Rep.	3
Papua New Guinea	3
Mongolia	4

LATIN AMERICA and CARIBBEAN

Brazil	1
El Salvador	1
Guatemala	1
Mexico	1
Nicaragua	1
Bolivia	2
Haiti	2
Argentina	3
Colombia	3
Cuba	3
Dominican Rep.	3
Ecuador	3
Honduras	3
Paraguay	3
Peru	3

Not listed in these tables are those countries where survey information or food consumption data show that vitamin A deficiency does not exist as a public health problem.

Lives on the line

Vitamin A supplementation could prevent 1 to 3 million child deaths each year. The estimate is imprecise because most countries have not investigated the full extent of their vitamin A deficiency problem. For the 12 countries listed below, sufficient information is available to estimate actual and potential numbers of lives saved by vitamin A supplementation.

These estimates assume that child mortality can be reduced by 23% in populations with xerophthalmia or other eye signs of vitamin A deficiency. This was the figure agreed by a United Nations expert committee after reviewing all of the vitamin A intervention studies so far undertaken.*

The 23% figure is likely to prove a conservative estimate. All the evidence now suggests that vitamin A supplementation can significantly reduce mortality even among children with mild deficiency and little or no xerophthalmia. Dr. Alfred Sommer, who led the research which linked vitamin A deficiency to higher child death rates (see article page 23), believes that supplementation could reduce child deaths by one third in many countries. Careful monitoring of large-scale interventions is now needed to quantify and confirm this effect.

* G. H. Beaton and others. *Effectiveness of vitamin A supplementation in the control of young child morbidity and mortality in developing countries.* ACC/SCN. Nutrition policy discussion papers no. 13, 1993.

The lives saved ... and the lives that could be saved

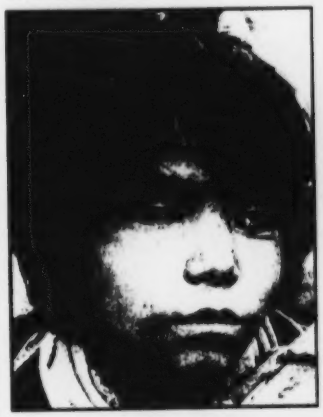
	% of young children in risk areas receiving supplements 1994	Lives saved 1994	Extra lives that could have been saved in 1994*
India	60	220000	145400
Bangladesh	94	70500	4500
Nepal	65	9800	5300
Brazil	59	9700	6800
Viet Nam	95	7800	450
Malawi	70	5000	2100
Zambia	60	4200	2800
Burkina Faso	30	2700	6300
Niger	24	2100	6700
Myanmar	6	1000	15700
Haiti	25	670	2000
Cambodia	5	410	7700

* If all children had received supplements

Source: Calculated from data supplied by UNICEF field offices

Two cents of prevention

White patches in the eye indicate severe vitamin A deficiency. But the threat to health and life begins long before the deficiency becomes visible.



Millions of young children worldwide are now receiving vitamin A supplements. The vitamin capsules cost approximately 2 cents each.

Making the A grade

Foods like eggs, papayas, and mangoes can prevent vitamin A deficiency in young children. But despite many attempts, there is no evidence to suggest that promoting the consumption of such foods has been effective on a large scale. Often, the message does not change diets enough, or does not reach those most in need, or fails to lift vitamin A to adequate levels. Recent research even casts doubt on the long-established notion that all green leafy vegetables will yield enough vitamin A.

The distribution of 2-cent vitamin A capsules every four to six months to young children is proving effective.

A third method is food fortification. Guatemala has taken the lead in fortifying sugar with vitamin A. The sugar industries in many other nations of Latin America, the Middle East and Africa could do the same.

In the Philippines, Procter & Gamble has recently increased tenfold the vitamin A content of its low-cost margarine. Unilever is considering the same step in a number of African countries. The costs are small, the impact large. All companies producing oils and fats in vitamin A-deficient countries should now consider this option.

NUTRITION ACHIEVEMENT ANI

Perceptions of the child malnutrition problem have changed significantly in recent years.

From being seen as a problem of protein, then calories, child malnutrition is now seen to be caused as much by frequent infection and poor feeding practices as by lack of food itself.

More recently still, awareness has spread of the importance of micronutrients such as iron, iodine, and vitamin A in promoting good health and nutrition.

Pakistan – 740,000 child deaths a year and half of them linked to malnutrition

Unmasking malnutrition

Over 8 million of the 13 million under-five deaths in the world each year can be put down to diarrhoea, pneumonia, malaria, and vaccine-preventable diseases. But this simple way of classifying hides the fact that death is not usually an event with one cause but a process with many causes. In particular, it is the conspiracy between malnutrition and infection which pulls many children into the downward spiral of poor growth and early death.

Nonetheless, the fact that it is possible to put dramatic figures on the disease element in this partnership has helped to focus attention on problems like measles and diarrhoeal disease – and on the availability of low-cost methods of preventing or treating them.

Now, a new study has attempted to quantify the role of malnutrition in child deaths.

Using data from 53 developing countries, researchers from Cornell University have concluded that over half of those 13 million child deaths each year are associated with malnutrition. Further, they show that more than three quarters of all these malnutrition-assisted deaths are linked not to severe malnutrition but to mild and moderate forms.

This contradicts the idea that death rates only rise when children are severely malnourished. By the same token, it suggests that nutrition programmes focusing only on the severely malnourished will have far less impact than programmes to improve nutrition among the much larger number of mildly and moderately malnourished children.

The method used in this calculation was developed from eight large-scale community studies. Despite very different settings, all of these studies demonstrated a remarkably consistent relationship between the risk of death and the child's weight-for-age.

This is the first time that such estimates have been made for so many countries using epidemiological methods. But confidence in the result is boosted by the fact that the overall findings conform well to the conclusions of the one large-scale clinical study that was conducted more than 20 years ago.

As discussed in the 1994 edition of *The Progress of Nations* (page 7), low-cost methods of reducing all forms of malnutrition are available and have been shown to work. And action on both fronts – to improve nutrition and to protect against disease – could save many more lives (and be far more cost-effective) than action on either front alone.

The table in the next column shows the role of malnutrition in child deaths for the 53 countries in which the new method has so far been applied.

Mild murder

Percentage of under-five deaths linked to malnutrition (selected countries)

	% of malnutrition-assisted deaths where malnutrition was mild or moderate only	% of all under-five deaths associated with malnutrition (all degrees)
India	74	67
Bangladesh	73	66
Nepal	80	65
Viet Nam	78	56
Pakistan	79	55
Indonesia	92	54
Haiti	79	53
Tanzania	93	53
Burundi	83	52
Nigeria	80	52
Sri Lanka	85	50
Myanmar	83	49
Guatemala	83	48
Madagascar	85	48
Mali	82	48
Philippines	93	46
Namibia	90	44
Rwanda	96	44
Djibouti	80	43
Ghana	90	42
Sierra Leone	83	42
Togo	88	41
Thailand	94	40
Zambia	91	40
Senegal	89	39
Uganda	91	39
Cape Verde	85	38
Guyana	94	37
Honduras	94	36
China	98	35
Ecuador	94	32
Morocco	95	31
Lesotho	100	29
Bolivia	100	27
Egypt	100	27
Brazil	99	26
Côte d'Ivoire	100	26
Antigua	92	25
Colombia	100	25
Iraq	100	25
Zimbabwe	100	24
Dominican Rep	100	23
Nicaragua	100	23
Peru	100	23
Tunisia	100	23
Uruguay	100	19
Jamaica	100	18
Jordan	100	17
Trinidad/Tobago	100	17
Barbados	100	15
Seychelles	100	15
Dominica	100	14
Paraguay	100	13

DISPARITY

Bangladesh: swelling of the thyroid gland (goitre) is a visible sign of iodine deficiency

50 close on salt target

Lack of iodine in the diet has condemned millions of children to cretinism, tens of millions to mental retardation, and hundreds of millions to milder degrees of mental and physical impairment. In total, 1.6 billion people in over 100 countries are at some degree of risk. The solution – employed in Europe and North America since the 1920s – is to iodize all edible salt at a cost of about 5 cents per person per year.

At the beginning of the 1990s, most of the affected countries agreed to attempt the iodization of at least 90% of all edible salt by the end of 1995. With less than a year to go, about 50 countries have a realistic chance of reaching that goal. Many others will surpass the 80% mark – putting them in a good position to reach the year 2000 target of virtually eliminating iodine deficiency.

India, which produces over 5 million metric tons of salt a year, has made massive efforts in the 1990s and now iodizes about two thirds of its salt. Nigeria, Africa's most populous country, has reached the 90% target within the last 12 months.

Meanwhile, a recent analysis of 21 research studies has shown that moderate iodine deficiency is associated with an average reduction of over 13 IQ points.

The table to the right shows the percentages of domestic and imported salt iodized in countries affected by iodine deficiency.

The problem has not entirely disappeared from the industrialized nations. In Luxembourg, for example, average daily consumption of iodine is well below the recommended level, and a campaign is now under way to persuade all bakers in the Duchy to use iodized salt in bread.

Table salt

Iodine deficiency disorders can be eliminated by iodizing all salt.

	% salt iodized		% salt iodized
Sub-Saharan Africa			
Cameroon	100	Niger	1
Nigeria	96	Angola	0*
Kenya	95	Benin	0
Rwanda	90	Burkina Faso	0
Burundi	80	Cote d'Ivoire	0*
Zambia	50	Guinea-Bissau	0
Sierra Leone	43	Mali	0
Tanzania	32	Namibia	0*
C. African Rep.	20	Togo	0
Middle East and North Africa			
Iraq	91	Syria	18*
Libya	90	Jordan	2
Algeria	80	Egypt	1
Iran	70	Morocco	0
Turkey	11	Yemen	0
South Asia			
Bhutan	100	Nepal	18
India	65	Pakistan	11
Bangladesh	18	Sri Lanka	4
East Asia and Pacific			
Thailand	50*	Myanmar	7
Viet Nam	24	Mongolia	0
Philippines	17		
Latin America and Caribbean			
Panama	95*	Chile	76
El Salvador	92*	Honduras	67*
Bolivia	90	Venezuela	65*
Peru	90	Paraguay	48
Ecuador	85	Dominican Rep.	2*
Brazil	84	Cuba	0*
Guatemala	80*		
Countries in transition			
Macedonia	100	Kazakhstan	10*
Yugoslavia	80	Ukraine	4*
Croatia	75	Romania	0
Belarus	37*	Russian Fed.	0*
Tajikistan	32*	Turkmenistan	0*
Hungary	10	Uzbekistan	0

* Legislation has set the minimum salt which is required
Only countries with salt iodization data are included
Updated from UNICEF Nutrition Section, Progress towards universal salt iodization, December 1994

19 nations still have no salt legislation

As at March 1995, there are 19 countries which are known to have iodine deficiency problems but which still have no legislation on salt iodization.

In most countries that have defeated iodine deficiency disorders, legislation has been a necessary but not sufficient condition. Educating consumers to choose iodized salt, and regular checks on salt producers, are also needed.

As in health or schooling, the list again shows that the countries that lag furthest behind are often those that are or have been affected by armed conflict or political turmoil.

Several of the world's poorest countries, including Bhutan, Bolivia, Cameroon, Kenya and Nigeria, have succeeded in iodizing the majority of salt consumed.

No salt laws

Afghanistan	Liberia
Albania	Lithuania
Azerbaijan	Mali
Cambodia	Mauritania
Estonia	Moldova
Fiji	Mongolia
Georgia	Mozambique
Haiti	Niger
Kyrgyzstan	Togo
Latvia	

Updated from UNICEF Nutrition Section, Progress towards universal salt iodization, December 1994

Without salt legislation, iodine deficiency can invisibly lower learning ability

Pakistan takes legal action

In the last few years, Pakistan has shown that it is possible for a large low-income country to move rapidly towards universal salt iodization.

Half of the nation's 130 million population are thought to be at risk. But in the severely affected north, consumption of iodized salt has jumped from 10% to 80% in less than a year.

A bill now before Parliament is expected to make salt iodization compulsory nationwide. "*The bill will have far-reaching effects on health and the quality of life,*" says the UNICEF office in Islamabad.

Even before the new law comes into effect, 468 salt producers have been identified, of which 232 have ordered the necessary machinery for adding iodine, and 157 are already producing iodized salt.

Consumers as well as producers are being targeted. Thousands of billboards, banners and posters are urging people to choose iodized salt – a message reinforced by mass media, health and immunization workers, schoolteachers, religious leaders, and local community organizations.

The new law is the result of many years of work by the Ministry of Health, WHO, UNICEF, the Programme Against Micronutrient Malnutrition, and the International Council for the Control of Iodine Deficiency Disorders.

Breastfeeding is the best possible start towards good health and nutrition throughout infancy and childhood.

In many cases, the advice given and the example set by hospitals and maternity units will determine whether an infant is fed by breast or bottle.

The 'baby-friendly hospital initiative' is an attempt by UNICEF and WHO to ensure that all hospitals offer the right advice and the necessary support to the mothers who must make this decision.

NUTRITION

ACHIEVEMENT AN

Baby-friendly hospitals reach 3000

The number of 'baby-friendly' hospitals has reached 3000 worldwide up from the 900 reported in last year's *Progress of Nations*.

Hospitals are awarded baby-friendly status when standard procedures in maternity wards are brought into line with the '10 steps to successful breastfeeding' drawn up in 1989 by WHO and UNICEF. Breastfeeding reduces the risk of malnutrition, infection, and death. According to WHO, over 1 million infant lives a year could be saved if all babies were exclusively breastfed for about the first six months. Hospitals and maternity units set a powerful example.

Most ministries of health have selected a number of influential hospitals to pioneer the baby-friendly idea. So far, over 130 countries have designated almost 9000 such 'target hospitals'. As of February 1995, over 3000 have earned the baby-friendly title.

In the last 12 months, several nations have lowered the number of target hospitals after realizing that sights had been set unrealistically high. Indonesia, for example, has reduced its number of target hospitals from 4000 to 217 while increasing the number of hospitals declared baby-friendly from 30 to 91. Similarly, the Philippines has lowered its target figure from 1600 to just over 600 while increasing those hospitals declared baby-friendly from 138 to 225. Figures for Viet Nam have also changed following a government decision to target only national and provincial hospitals in the first phase.

In some cases, a fall in the number of baby-friendly hospitals is a sign of commitment to the idea: Guatemala, for example, has reinspected all of its baby-friendly hospitals after one year and decided that 11 of them must bring the training of new staff up to standard in order to retain the title.

The front runners

Approximately 90% of the increase in baby-friendly hospitals over the last 12 months is accounted for by the following 15 countries:

Number of baby-friendly hospitals

	1993	1994	Rise
China	207	947	740
Thailand	45	440	395
Kenya	22	232	210
Mexico	55	224	169
Tunisia	13	118	105
Philippines	138	225	87
India	33	104	71
Ecuador	3	65	62
Indonesia	30	91	61
Iran	11	68	57
Bangladesh	3	48	45
Myanmar	4	47	43
Oman	23	51	28
Sweden	28	50	22
Cuba	3	23	20

Hospital roll-call

The following developing countries are listed in alphabetical order as comparisons are not possible between countries which, apart from differences in size, are operating at different levels of ambition.

	Target hospitals	Declared baby-friendly	% of target 1994
Sub-Saharan Africa			
Benin	40	12	30
Botswana	10	4	40
Burkina Faso	21	2	10
Burundi	32	1	3
Congo	12	6	50
Côte d'Ivoire	86	53	62
Gabon	12	2	17
Guinea	35	1	3
Kenya	300	232	77
Lesotho	18	4	22
Liberia	7	2	29
Mali	50	1	2
Namibia	20	17	85
Nigeria	200	17	9
Rwanda	2	2	100
Sao Tome/Principe	2	1	50
Sierra Leone	10	1	10
South Africa	-	1	-
Swaziland	6	4	67
Tanzania	174	5	3
Uganda	20	11	55
Zambia	40	5	13
Zimbabwe	25	14	56
Middle East and North Africa			
Algeria	5	2	40
Bahrain	6	6	100
Djibouti	8	4	50
Egypt	106	7	7
Iran	315	68	22
Kuwait	2	2	100
Lebanon	15	2	13
Oman	51	51	100
Saudi Arabia	172	2	1
Syria	30	11	37
Tunisia	151	118	78
Turkey	54	19	35
U. Arab Emirates	6	4	67

	Target hospitals	Declared baby-friendly	% of target 1994
South Asia			
Bangladesh	160	48	30
Bhutan	6	1	17
India	1000	104	10
Pakistan	100	7	7
Sri Lanka	214	37	17
East Asia and Pacific			
China	1000	947	95
Fiji	5	1	20
Indonesia	217	91	42
Korea, Dem.	12	1	8
Korea, Rep.	75	7	9
Malaysia	84	14	17
Mongolia	27	7	26
Myanmar	93	47	51
Philippines	612	225	37
Thailand	791	440	56
Viet Nam	58	1	2
Latin America and Caribbean			
Argentina	30	4	13
Bolivia	14	9	64
Brazil	54	13	24
Chile	40	11	28
Colombia	90	12	13
Costa Rica	26	1	4
Cuba	63	23	37
Dominican Rep.	25	2	8
Ecuador	104	65	63
El Salvador	28	14	50
Guatemala	49	12	24
Honduras	14	3	21
Mexico	750	224	30
Panama	4	1	25
Paraguay	12	2	17
Peru	70	27	39
Saint Vincent/ Grenadines	1	1	100
Venezuela	14	1	7

DISPARITY

Baby-friendly hospitals – Sweden leads the way

Sweden leads, US lags

In 1990, 31 governments met with UNICEF and WHO at the Innocenti Centre in Florence to draft the *Innocenti Declaration on the promotion, protection and support of breastfeeding*. The Declaration set out operational targets for all countries to achieve by 1995.

This is 1995. No government has yet reached all the targets, and most of the Declaration's signatories are still some way from reaching the goals.

The United States, which also co-sponsored the original Innocenti meeting, is showing no progress in any of the four areas: it has no national breastfeeding committee, no baby-friendly hospitals, no regulations on the marketing of breastmilk substitutes, and no right to paid maternity leave and breastfeeding breaks at work.

In the industrialized world, Sweden leads the way. Of the country's 66 maternity units, 50 are already declared baby-friendly.

The chart below shows progress – or the lack of it – being made by the 31 countries that drew up the Declaration. All except Mauritius, the U.S. and Zaire have national breastfeeding committees.

The Innocenti

The chart shows not whether targets are achieved but whether some progress is being made.

	Baby-friendly hospitals designated	Some breastmilk substitute marketing regulations	At least minimum maternity benefits provided
Bangladesh	Yes	Yes	No
Brazil	Yes	Yes	Yes
Chile	Yes	Yes	Yes
China	Yes	Yes	Yes
Colombia	Yes	Yes	Yes
Côte d'Ivoire	Yes	Yes	Yes
Ecuador	Yes	Yes	Yes
Ethiopia	No	Yes	No
Guatemala	Yes	Yes	Yes
Honduras	Yes	Yes	No
India	Yes	Yes	Yes
Indonesia	Yes	Yes	No
Iran	Yes	Yes	Yes
Italy	No	No	Yes
Jordan	No	Yes	No
Kenya	Yes	Yes	No
Mali	Yes	No	Yes
Mauritius	No	Yes	No
Mexico	Yes	Yes	Yes
Nigeria	Yes	Yes	Yes
Pakistan	Yes	Yes	No
Poland	Yes	No	Yes
Swaziland	Yes	Yes	No
Sweden	Yes	Yes	Yes
Tanzania	Yes	Yes	No
Thailand	Yes	Yes	No
Turkey	Yes	Yes	Yes
United Kingdom	No	Yes	No
United States	No	No	No
Zaire	No	Yes	Yes
Zimbabwe	Yes	Yes	Yes

Neglected anaemia problem lowers productivity of nations

Latest estimates suggest that half the children of Africa and South Asia are anaemic. Unfortunately, those latest estimates are almost 15 years old. And despite the seriousness of the problem, only two of the 10 most populous countries of the developing world, Pakistan and the Philippines, have conducted a nationwide survey of anaemia in children during the past decade.

For the quarter of a billion or more affected children in the developing world, such neglect has heavy if invisible consequences. Mental growth can be retarded by neurological damage, and there is strong evidence to show a measurable loss of IQ points in anaemic children. In more severe cases, child death rates rise.

As recorded in *The Progress of Nations 1994*, anaemia also affects about 40% of the developing world's women – a figure that rises to over 50% in pregnant women (leading to increased risks of maternal death and low birth weights). In many countries, about a quarter of adult men have also been found to be anaemic.

Anaemia on this scale, says a recent report from WHO and UNICEF, *"lowers the productivity of entire populations."*

The most common cause of anaemia is low absorption of iron from food. Breastfeeding gives adequate iron for the first six months. But most weaning foods – including milk products and cereals – are low in iron unless specifically fortified.

Increasing iron intake is only part of the answer. Drinking tea with a meal, for example, reduces iron absorption, while eating meat or fruit rich in vitamin C means that two or three times as much iron is absorbed.

The diets of the poor – and particularly of the vegetarian poor, who cannot always afford fruit – therefore pose a significant risk.

As with vitamin A deficiency, there are three possible solutions – changing cooking and eating habits, fortifying staple foods, or distributing iron supplements in tablet or syrup form where iron deficiency anaemia is known to be a problem. UNICEF and WHO recommend simultaneous action on all three fronts (including supplementation for children aged six months to five years where anaemia is a problem).

WHO and UNICEF are now working with governments to develop national anaemia plans by the end of 1995, and to reach the goal of eliminating iron deficiency anaemia as a major problem by the year 2000.

The latest research findings could help. Part of the problem with iron tablets has always been that they taste bad, turn faeces black, and have to be taken daily. Recent research suggests that taking the tablets once a week is almost as effective – and likely to be more effective because more widely accepted. A study in Indonesia has also shown that iron supplements alone reduce the problem by about 70% – but by over 95% if iron supplements are combined with a small dose of vitamin A.

Anaemic statistics

% of under-fives suffering from iron deficiency anaemia, around 1980 (WHO regions)

Africa	56
South Asia	56
Latin America	26
East Asia	20
Oceania	18
Europe	14
North America	8

Half of South Asia's children anaemic

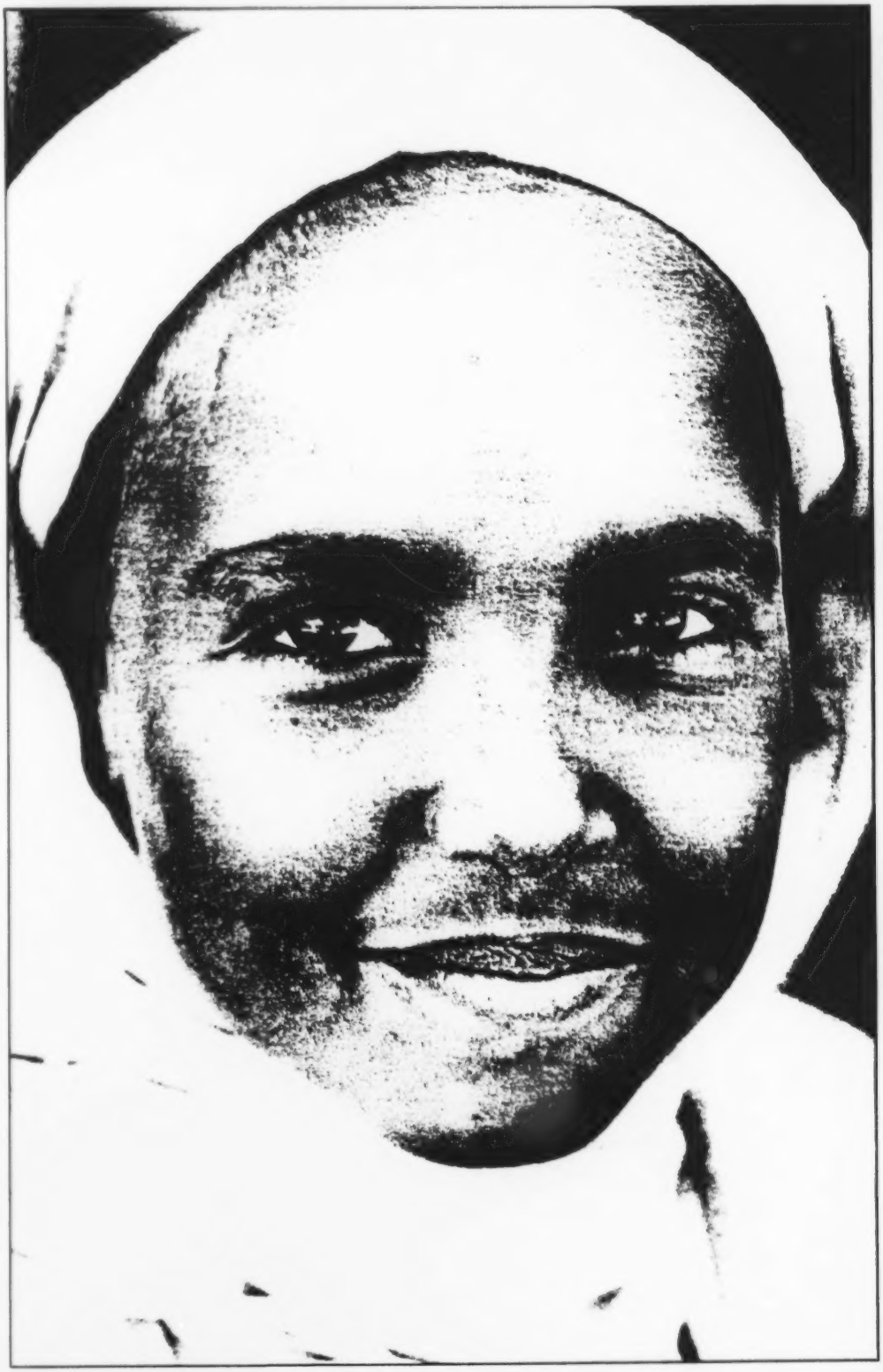
EDUCATION

COMMENTARY

Only since the 1950s, with the coming of independence to much of the developing world, has 'education for all' been taken seriously.

School enrolment then doubled in one generation. But in the 1980s, debt and economic adjustment took their toll on the education of millions of today's teenagers.

Today, progress is being renewed. But education is no longer a numbers game. Success or failure depends now on the quality and relevance of the education being offered.



More of the same will not be enough

Victor Ordoñez

Victor Ordoñez, a former Deputy Minister for Education in the Philippines, is Director of the Division of Basic Education, UNESCO, Paris.

About a third of the children of the developing world are failing to complete even four years of education, either because they drop out of school early, or because they never enrol in school at all. For many societies, therefore, development's most basic building block is not yet in place.

In an attempt to renew the momentum of education, the 1990s opened with a World Conference on Education for All in Jomtien, Thailand. Practical results are now beginning to emerge.

In Latin America, there has been an average increase of about 40% in government spending on education in the last five years. Statistics are slow to reflect the change; but the alarming rates of school drop-out in many Latin American countries are now beginning to improve.

In nine of the most populous developing nations, with half of the world's children, all but Nigeria and Pakistan are sharply increasing resources for primary education (the situation in Brazil is not yet clear).

Internationally, the World Bank has kept the promise made at Jomtien: its lending for basic education has tripled to $1 billion.

Equally important are changes in attitudes: a decade ago, it was rare to hear government ministers talking about the importance of female education; today, it sometimes seems that they talk of little else. If followed by an equivalent practical breakthrough, this will be a major step forward not just for women but for development.

Finally, the 1990s have also been marked by a real breakthrough in preschool education. In five years, the number of children enrolled in early childhood education has risen by over 40% from about 45 million to about 65 million worldwide.

Despite all this, the advance is not rapid enough to meet the goal of education for all by the year 2000.

In part, the problem is the exclusion of so many children by barriers of language, tribe, caste, religion, culture, economic class, or geographic inaccessibility. The traditional response – expanding existing education systems – fails to recognize that these groups are precisely those who find such existing education systems unsuitable for their needs, their circumstances, their aspirations and their difficulties. The problem of reaching the unreached will therefore not be solved by more of the same.

In countries where the unreached are a majority, principally in sub-Saharan Africa and South Asia, conventional education systems are often not only unaffordable and irrelevant but also alienating to many of those they are intended to serve.

Radical alternatives are being pioneered. In some areas of Ethiopia, for example, traditional primary schools are being replaced by village educational centres – part day-care centre, part primary school, part adult learning centre – where skilled or literate adults do much of the teaching, where timetables bow to the needs of the agricultural seasons, and where the community is involved both in deciding on learning needs and in meeting them.

Where the great majority of children do enter school, the central problem is the poor quality and low perceived relevance of the education on offer – and the high drop-out rates that are the result. And when so many of those who do complete school cannot find jobs, millions of parents and pupils are voting with their feet.

It is not enough to say that these problems go beyond the scope of schools. There is much that can be done to make existing school systems work better – especially for girls.

The sheer scale of the task – providing many years of education for the 100 million children who enter primary school every year – means that there are no short cuts. Steady, unspectacular improvements will have to be made in teacher training and supervision, in learning materials and school facilities, in curriculum content, and in catering for the special needs of the 10% of children in most classrooms who have mild or moderate learning difficulties.

In many nations, such efforts need to be targeted to particular regions and schools. A recent example is the '900 schools' programme in Chile, which identified the schools with the lowest performance in the country and brought increased resources and more imaginative approaches to bear on their problems. A similar attempt is now being made in 19 selected provinces in the Philippines.

Most countries could achieve basic education for all if they spent more on primary schools than on higher education. In practice, this can probably only be achieved by differential rates of growth. India has announced plans to quadruple spending on primary education over the next five years, while increasing the budget for higher education by 50%.

In many countries, aid will also be needed. At the moment, only 2% of aid goes to primary education.

Even for those who are in school, we need to look closely at doing the right things rather than just doing things right. We must face anew the problem of education systems that turn out graduates who cannot find jobs, students who do not wish to return to their own communities, and young people who are ill equipped to cope with either the difficulties or the opportunities they will face.

In recent decades, there has been progress in the skills of imparting literacy and numeracy, but there has been comparatively little progress in imparting life skills, social skills, and value skills. We can produce experts in information technologies, but we seem unable to improve a capacity for listening, for tolerance, for respecting diversity, for harnessing the potential of individuals to the social good, or for strengthening the ethical foundations without which skills and knowledge bring little benefit.

In almost all countries, young adults are faced with unprecedented tensions, challenges and temptations for which their school years have done little to prepare them. Often, the very structure and the role models set before them in schools stress one-way communication in an atmosphere of rigid repression and uniformity, rather than participation and diversity, so reinforcing patterns of demagoguery and conflict rather than of openness and tolerance. This is a poor preparation for life in the 21st century; it meets neither the personal needs of individuals nor the developmental needs of their societies.

In most attempts at fundamental reform, community involvement has been the key. The alienation and irrelevance of education seem to be related to the fact that learners and their communities are treated as passive recipients – without inviting any of their own input, involvement and commitment. Returning ownership of education to the community naturally leads to a re-examination of its content and purpose, and of its relationship to employment, to increased productivity, to local opportunity and need, and to the development of life skills. It also means that education systems are likely to support rather than undermine family responsibility for children.

By both conventional and unconventional methods, the commitment towards education for all is being renewed. For despite the many competing priorities, awareness is growing that the failure to educate is likely to mean failure to solve environmental problems, failure to reduce population growth, failure to accelerate economic development, and failure to maintain the fabric of society itself.

EDUCATION

NATIONAL PERFOR

The tables on these pages show each country's national performance gap in primary education.

The national performance gap is the difference between each country's achievement and the average achievement for countries at the same level of economic development.

The figure in parentheses represents the actual percentage of children reaching grade 5.

The national performance gap can be calculated for various indicators of social progress (see pages 50 to 51).

SUB-SAHARAN AFRICA

1	Kenya (77)	+ 32
2	Rwanda (60)*	+ 22
3	Togo (70)	+ 21
4	Burundi (53)	+ 17
4	Ghana (72)	+ 17
6	Zimbabwe (76)	+ 16
7	Zambia (67)	+ 15
8	Mauritius (95)	+ 10
9	Zaire (50)	+ 9
10	Nigeria (56)	+ 8
11	Mauritania (63)	+ 5
12	Mozambique (23)	+ 4
13	Congo (72)	+ 1
14	Botswana (84)	0
14	Tanzania (24)	0
14	Uganda (37)	0
17	Cameroon (66)	– 1
17	Chad (37)	– 1
19	Benin (49)	– 5
20	Côte d'Ivoire (54)	– 9
21	C. African Rep. (43)	– 10
22	Malawi (27)	– 13
23	South Africa (71)	– 14
24	Ethiopia (9)	– 15
24	Senegal (51)	– 15
26	Lesotho (47)	– 17
27	Namibia (64)	– 18
28	Guinea-Bissau (20)	– 20
28	Madagascar (22)	– 20
30	Burkina Faso (26)	– 21
31	Niger (23)	– 22
32	Mali (22)	– 25
33	Angola (34)	– 31
34	Guinea (26)	– 32
35	Gabon (50)	– 37
	Somalia	OLD DATA
	Eritrea	NO DATA
	Liberia	NO DATA
	Sierra Leone	NO DATA

MIDDLE EAST and NORTH AFRICA

1	Egypt (93)	+ 29
2	Jordan (98)	+ 21
3	Syria (91)	+ 15
4	Algeria (93)	+ 11
5	Tunisia (90)	+ 8
6	Yemen (66)	+ 7
7	Iran (89)	+ 6
7	Turkey (89)	+ 6
9	U. Arab Emirates (99)	+ 3
10	Morocco (76)	+ 2
10	Sudan (56)	+ 2
12	Oman (85)	– 3
13	Kuwait (83)	– 13
14	Iraq (66)	– 15
15	Saudi Arabia (71)	– 19
	Lebanon	NO DATA
	Libya	NO DATA

SOUTH ASIA

1	Sri Lanka (92)	+ 30
2	Nepal (52)	+ 18
3	India (62)	+ 16
4	Bangladesh (47)	+ 7
5	Pakistan (37)	– 18
6	Bhutan (9)	– 26
7	Afghanistan (13)	– 33

Gap between the actual and expected percentage of children reaching grade 5 of primary school

(figures in parentheses show the actual percentage of children reaching grade 5)

Schooling per dollar

Using data from all developing countries, it is possible to calculate an average figure for the percentage of children who reach grade 5 of primary school at each different level of economic development.

In many countries, the percentage of children reaching grade 5 is above that average – i.e. higher than expected for the country's GNP. In other countries, the percentage reaching grade 5 is lower than the average for that level of GNP.

This difference between actual and average levels of performance is the national performance gap.

The national performance gap is not applicable in industrialized nations, where almost all children complete four grades of primary education.

National performance gaps

Developing countries where the percentage of children reaching grade 5 of primary school is 20 points or more above the level that could be expected for GNP

Kenya	+32	Rwanda*	+22
China	+30	Jordan	+21
Sri Lanka	+30	Togo	+21
Egypt	+29	Indonesia	+20
Viet Nam	+23		

* Figures predate the major events of 1994

MANCE GAPS

EAST ASIA and PACIFIC

1	China (88)	+ 30
2	Viet Nam (58)	+ 23
3	Indonesia (86)	+ 20
4	Malaysia (92)	+ 7
5	Philippines (75)	+ 6
6	Hong Kong (99)	+ 5
6	Lao Rep. (54)	+ 5
6	Singapore (100)	+ 5
6	Thailand (88)	+ 5
10	Korea, Rep. (93)	+ 3
11	Papua New Guinea (66)	– 9
	Cambodia	NO DATA
	Korea, Dem.	NO DATA
	Mongolia	NO DATA
	Myanmar	NO DATA

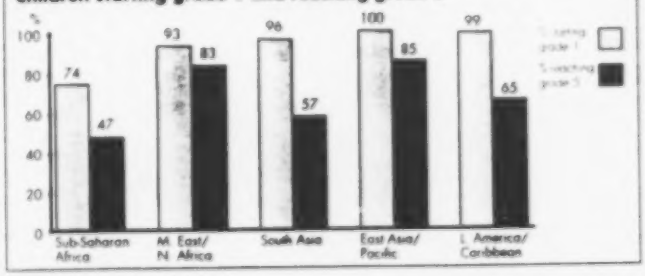
LATIN AMERICA and CARIBBEAN

1	Cuba (95)	+ 19
2	Jamaica (96)	+ 16
3	Uruguay (95)	+ 9
4	Chile (93)	+ 8
5	Nicaragua (55)	+ 4
6	Costa Rica (86)	+ 3
7	Mexico (84)	– 2
7	Panama (82)	– 2
9	Bolivia (60)	– 7
9	Paraguay (74)	– 7
9	Venezuela (78)	– 7
12	Ecuador (67)	– 9
13	Trinidad/Tobago (69)	– 17
14	Honduras (41)	– 20
15	Colombia (59)	– 21
15	El Salvador (58)	– 21
17	Brazil (56)	– 29
18	Dominican Rep. (41)	– 34
18	Guatemala (41)	– 34
20	Haiti (12)	– 40
	Peru	OLD DATA
	Argentina	NO DATA

Staying the course

Most of the world's children start primary school. But drop-out rates are often high, and it is this drop-out factor which accounts for most of the differences between regions.

Children starting grade 1 and reaching grade 5



Life skills

As the content and the relevance of education are increasingly called into question, many school systems are beginning to include life skills as well as formal learning.

Knowledge about how to avoid contracting HIV, the virus that leads to AIDS, now counts as a life-or-death skill for young people in all countries.

When Michael Merson, Director of the WHO Global Programme on AIDS, was recently asked, *"If you could do only one or two things for AIDS prevention what would they be?"* he replied, *"Sex education in all primary and secondary schools."*

Up-to-date information on school curricula in all countries is not available. But the following list, compiled from WHO questionnaires sent out to governments in late 1992, shows how nations have been moving to incorporate AIDS education in the curriculum.

Worldwide 15 million people are now infected with HIV.

One million are children.

Curriculum vitae

The following table shows which countries have introduced education about sexually transmitted diseases, including AIDS.

1985	Sweden				
1986	Burkina Faso	Norway	Singapore	Sri Lanka*	
1987	Canada	France	Honduras	Japan	United States**
1988	Barbados	Burundi	Luxembourg	Seychelles	Zaire
1989	Australia	Kuwait	Russian Fed.	Tonga	
	China	Libya	Slovenia	Tunisia	
	Germany	Papua New Guinea	Thailand	Uganda	
1990	Azerbaijan	Colombia	Grenada	Madagascar	Syria
	Bahamas	Croatia	Hong Kong	New Zealand	
	C. African Rep.	Gabon	Latvia	Sierra Leone	
1991	Argentina	Ghana	Morocco	Samoa	Venezuela
	Cameroon	Iraq	Netherlands	Senegal	Viet Nam
	Congo	Malawi	Palau	Swaziland	
	Czech Rep.	Malaysia	Panama	Togo	
	El Salvador	Micronesia, Fed. States	Saint Lucia	Trinidad/Tobago	
1992	Algeria	Cyprus	Kenya	Spain	United Kingdom
	Botswana	Jamaica**	Montserrat	Sudan	Zambia
1993	Italy				
AIDS in curriculum: starting year not specified	Austria	Denmark	Guatemala	Lesotho	Zimbabwe
	Belgium	Gambia	Israel	Switzerland**	
AIDS not in curriculum (early 1993)	Albania	Chad	Guinea-Bissau	Mozambique	Slovakia
	Angola	Chile	Hungary	Myanmar	Solomon Islands
	Antigua/Barbuda	Comoros	India	Namibia	Tanzania
	Bangladesh	Cook Islands	Indonesia	Nepal	Turkey
	Belize	Costa Rica	Iran	Niger	Tuvalu
	Benin	Côte d'Ivoire	Jordan	Nigeria	Uruguay
	Bhutan	Djibouti	Kiribati	Pakistan	Vanuatu
	Bolivia	Dominican Rep.	Lao Rep.	Paraguay	Yemen
	Brazil	Ecuador	Lebanon	Philippines	
	Brunei Darussalam	Egypt	Lithuania	Romania	
	Cambodia	Equatorial Guinea	Maldives	Rwanda	
	Cape Verde	Ethiopia	Mauritius	Saudi Arabia	
Curriculum information not supplied	Fiji	Marshall Islands	Ukraine		

* Nationally transmitted diseases. ** Coverage varies.

Use of WHO questionnaires sent to governments in late 1992 cited in UNAIDS, AIDS, images of the epidemic, 1994.

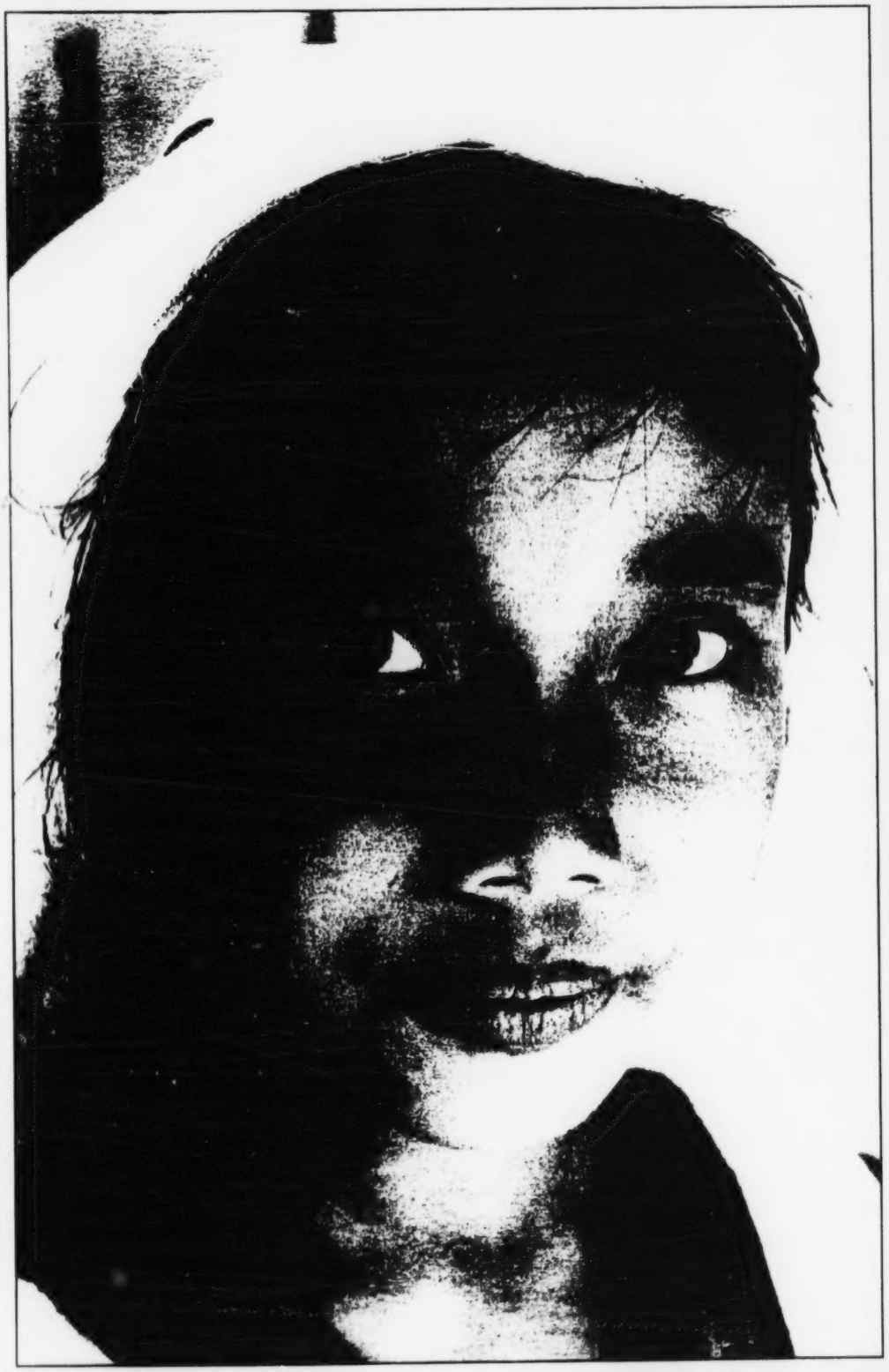
FAMILY PLANNING

COMMENTARY

The 1994 Cairo International Conference on Population and Development drew on three decades of experience to reach a new consensus for the decades ahead.

The Conference broadened the approach by emphasizing progress towards equality for women, reducing maternal and child mortality, and ensuring access for all girls and women to basic education and health services – including reproductive health and family planning.

In this article, Judith Bruce and Anrudh Jain examine how family planning services are, or should be, affected by the Cairo consensus.



A new family planning ethos

Judith Bruce and Anrudh Jain

Judith Bruce is Senior Associate, and Anrudh Jain is Director of Programmes, Programmes Division, the Population Council, New York.

A long overdue revolution in family planning is under way.

Since modern methods of family planning began to be made available in the 1950s and 1960s, the mandate of those who provide the services has often been ambiguous.

On the one hand, most family planning workers are motivated by a wish to help individuals choose safe and acceptable means to space or limit pregnancies. On the other hand, fears about rapid population growth are a powerful lever for dislodging the funds for family planning programmes, and this has led some managers to feel that their real priority is to reduce fertility.

Many programmes have been caught between these two conflicting mandates. Often the demographic imperative, and the funds that accompany it, have proved the weightier. Where this has happened, family planning programmes have often come to emphasize quantity over quality, coverage over service, and population worries over individual needs.

The same influence can be seen in the criteria commonly used for measuring the effectiveness of such programmes – 'acceptance rates', 'couple-years of protection', or even 'proportion of women using long-term methods of family planning'.

Unwanted fertility

At the heart of these conflicting pressures is the lack of a clear distinction between wanted and unwanted fertility, and a corresponding confusion about what family planning can and cannot do.

Social and economic change can cause people to want to space births or to have fewer children. Family planning programmes can permit the safe exercise of such choices.

In free societies, family planning programmes prevent only *unwanted* fertility – which may be as low as 5% in some developing countries and as high as 25% in others. But to do so effectively and sensitively, they must have the clear and single mandate of assisting individuals and couples to avoid the pregnancies which they themselves define as unwanted.

The main job of family planning programmes is therefore not to promote smaller families *per se* but to meet existing demand with services that are respectful and competent.

When this is accepted as the unambiguous mandate, then the emphasis inevitably shifts to the quality of services being offered and their responsiveness to individuals' requirements.

As the quality of service becomes the paramount consideration, the criteria for evaluating programmes also change. Intermediate goals become important – the ability to offer a choice of methods, the provision of adequate information to guide that choice, the technical competence to provide the various methods safely, the respect shown for dignity and privacy, and the long-term care of each individual.

This new emphasis on individual care would improve most family planning programmes. It would revolutionize others.

Because of past emphasis on quantity, there have been relatively few evaluations of quality. But from the studies that are available, disturbing findings have emerged. In one survey in Tanzania, for example, fewer than one third of women attending a family planning clinic were even asked about their reproductive intentions. In another study in Nairobi, fewer than half of family planning providers washed their hands before performing a pelvic examination. In an observation study in Bangladesh, only 9 out of 19 workers washed their hands before inserting an IUD.

In general, individuals are receiving insufficient information to make a well-founded choice. In some programmes, consultations are far from private. In many cases, reproductive health issues are not on the agenda.

In the worst of these programmes, the number of users is less a measure of the quality of service than of the desperation of those who use them.

Many programmes are now attempting to reverse this neglect.

Paradoxically, all of the evidence suggests that improving the quality of family planning services would also be the best way of meeting unmet demand, of uncovering any latent demand, and of ensuring that those who come to family planning clinics continue to plan their families, according to their needs, over their child-bearing years. Indeed the evidence from most countries suggests that family planning programmes that truly help individuals to achieve their own reproductive goals also have a greater impact on reducing fertility than programmes that are motivated and measured by demographic targets.

The recent round of Demographic and Health Surveys, for example, shows very high levels of early drop-out in some programmes – an indication that the problem is not lack of 'coverage' but lack of satisfaction with the method or quality of service being offered.

Client-centred

In particular, long-term contraceptive use is usually significantly higher if family planning services offer a choice – not just in the first instance, but over time – rather than promoting any one particular method. A study in Indonesia, for example, revealed that 85% of women who had not received the contraceptive of their choice had dropped out of the programme within one year; of those who were using the method of their choice, only 25% had dropped out.

In other words, it is clear that a range of methods, competently provided, will attract more users and permit the switching between methods that is the foundation of satisfied and sustained use of contraceptives.

Similarly, unwarned-of and unattended side-effects are a major cause of dissatisfaction with family planning services, and of the discontinuation of contraception. This too can only be remedied by better-quality and more client-centred family planning services.

For all of these reasons, it must now be considered irresponsible to manage and measure family planning programmes by the use of targets or quotas for specific methods. For such criteria threaten the very ethos of client-oriented, high-quality family planning services.

Instead, the success and efficiency of family planning services should be evaluated by how well they enable people to meet their own reproductive goals in a healthy way. This is certainly more difficult to measure than the number of acceptors, but it is by no means impossible. It requires, first of all, an understanding of the individual's reproductive intentions. We have proposed a method of evaluation – the HARI index (standing for 'Helping Achieve Reproductive Intentions') – which would follow a sample of clients over time to find out what proportion met their reproductive goals in a safe and healthy way.

Finally, family planning programmes must begin to play a part in supporting voluntary and equal sexual partnerships. A few brave programmes are now seeking to help their clients, usually women, to involve their partners, if they wish, in taking responsibility for reproductive health, family planning and, eventually, close involvement with wanted children. Such services are concerning themselves with the woman's unequal status in so many of the decisions that affect her sexual and reproductive health, and they are beginning to grapple with the harsh social realities of women's lives, including male dominance in sexuality and in making decisions over fertility.

In other words, the better family planning programmes are working to deserve their names – by providing a genuine service not just to individuals and couples, but to families.

FAMILY PLANNING

LEAGUE TABLE OF

These pages list nations according to their falls in fertility over the last three decades.

Countries that had already achieved low fertility 30 years ago obviously had less scope for further reductions.

Falling fertility reflects the changing conditions which lead people to want smaller families. It also reflects the spread of family planning programmes that enable people to exercise that choice. In some cases, it reflects, also, the desperation of women who will tolerate poor family planning services, or seek abortions.

SUB-SAHARAN AFRICA

		Births
1	Mauritius (5.6)	– 3.3
2	Zimbabwe (7.5)	– 2.5
3	South Africa (6.4)	– 2.3
4	Botswana (6.9)	– 2.1
5	Kenya (8.1)	– 1.9
6	Rwanda (7.7)	– 1.2
7	Mauritania (6.5)	– 1.1
8	Ghana (6.9)	– 1.0
8	Senegal (7.0)	– 1.0
10	Tanzania (6.8)	– 0.9
11	Namibia (6.0)	– 0.8
12	Eritrea (6.5)	– 0.7
12	Zambia (6.6)	– 0.7
14	Lesotho (5.8)	– 0.6
15	Madagascar (6.6)	– 0.5
▶	*Regional average*	*–0.4*
16	Cameroon (5.9)	– 0.2
17	Burundi (6.8)	– 0.1
17	Chad (6.0)	– 0.1
17	Nigeria (6.5)	– 0.1
17	Togo (6.6)	– 0.1
21	C. African Rep. (5.7)	0.0
21	Guinea (7.0)	0.0
21	Mali (7.1)	0.0
21	Niger (7.4)	0.0
21	Somalia (7.0)	0.0
26	Benin (7.0)	+ 0.1
26	Burkina Faso (6.4)	+ 0.1
26	Côte d'Ivoire (7.3)	+ 0.1
26	Ethiopia (6.9)	+ 0.1
26	Liberia (6.7)	+ 0.1
26	Malawi (7.0)	+ 0.1
26	Mozambique (6.4)	+ 0.1
33	Congo (6.0)	+ 0.2
33	Sierra Leone (6.3)	+ 0.2
35	Uganda (6.9)	+ 0.3
36	Angola (6.4)	+ 0.7
36	Guinea-Bissau (5.1)	+ 0.7
36	Zaire (6.0)	+ 0.7
39	Gabon (4.1)	+ 1.3

MIDDLE EAST and NORTH AFRICA

		Births
1	Kuwait (7.3)	– 4.2
2	Tunisia (7.1)	– 4.0
3	Algeria (7.4)	– 3.6
4	Morocco (7.1)	– 3.4
5	Egypt (7.0)	– 3.2
5	Lebanon (6.3)	– 3.2
7	Turkey (6.1)	– 2.8
8	U. Arab Emirates (6.9)	– 2.7
9	Jordan (8.0)	– 2.5
▶	*Regional average*	*–2.4*
10	Iran (7.2)	– 2.2
11	Syria (7.5)	– 1.7
12	Iraq (7.2)	– 1.5
13	Saudi Arabia (7.3)	– 1.0
13	Sudan (6.7)	– 1.0
15	Libya (7.2)	– 0.9
16	Oman (7.2)	– 0.1
17	Yemen (7.6)	0.0

SOUTH ASIA

		Births
1	Sri Lanka (5.1)	– 2.6
2	Bangladesh (6.7)	– 2.4
3	India (5.8)	– 2.1
▶	*Regional average*	*1.9*
4	Pakistan (7.0)	– 0.9
5	Nepal (5.7)	– 0.3
6	Afghanistan (7.0)	– 0.2
7	Bhutan (5.9)	– 0.1

Change in the number of births per woman 1963-1993

*(figures in **parentheses** show average births **per woman** in 1963)*

Changing needs

Apart from the suitability of different methods of family planning for different people, a choice of methods may also be needed as reproductive intentions change. Some may wish to postpone a first pregnancy, others to space births, still others to end child-bearing.

The table derived from Demographic and Health Surveys (DHS) interviews in five high-fertility countries and six low-fertility countries, shows how women responded when asked about their wishes.

Seven or more births per woman

	Births per woman 1993	% wishing to postpone pregnancy	% wishing to end child-bearing
Niger	7.4	14	5
Uganda	7.2	20	7
Mali	7.1	17	6
Malawi	7.1	20	17
Guinea	7.0	18	6

Under three births per woman

	Births per woman 1993	% wishing to postpone pregnancy	% wishing to end child-bearing
Brazil	2.9	5	8
Indonesia	2.9	6	6
Colombia	2.7	3	12
Sri Lanka	2.5	7	5
Trinidad/T.	2.4	8	8
Thailand	2.1	6	6

United Nations, Department of Economic and Social Information and Policy Analysis, Population Division, World population prospects, the 1994 revision. 1994. Family planning demand satisfied: high. The impact of the population new survey findings. Population reports, series M, no. 11. December 1992.

FALLING FERTILITY

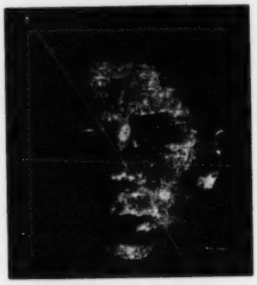
EAST ASIA and PACIFIC

		Births
1	Thailand (6.4)	– 4.3
2	Hong Kong (5.2)	– 4.0
3	China (5.6)	– 3.6
3	Korea, Rep. (5.3)	– 3.6
5	Korea, Dem. (5.9)	– 3.5
▶	*Regional average*	*– 3.4*
6	Singapore (4.8)	– 3.1
7	Malaysia (6.6)	– 3.0
8	Philippines (6.6)	– 2.7
9	Indonesia (5.4)	– 2.5
9	Mongolia (6.0)	– 2.5
11	Viet Nam (6.0)	– 2.2
12	Myanmar (6.0)	– 1.9
13	Papua N. Guinea (6.3)	– 1.3
14	Cambodia (6.3)	– 1.1
15	Lao Rep. (6.2)	+ 0.4

Since 1970, the developing world has progressed, on average, about halfway towards the replacement fertility level of just over two births per woman.

LATIN AMERICA and CARIBBEAN

		Births
1	Dominican Rep. (7.3)	– 4.2
2	Colombia (6.7)	– 4.0
3	Costa Rica (6.8)	– 3.7
4	Mexico (6.7)	– 3.5
5	Jamaica (5.7)	– 3.4
5	Peru (6.8)	– 3.4
7	Venezuela (6.6)	– 3.3
8	Brazil (6.1)	– 3.2
8	Ecuador (6.7)	– 3.2
10	Panama (5.9)	– 3.0
11	Cuba (4.6)	– 2.8
11	El Salvador (6.8)	– 2.8
▶	*Regional average*	*– 2.8*
13	Chile (5.2)	– 2.7
14	Honduras (7.4)	– 2.5
14	Paraguay (6.8)	– 2.5
14	Trinidad/Tobago (4.9)	– 2.5
17	Nicaragua (7.4)	– 2.4
18	Bolivia (6.6)	– 1.8
19	Guatemala (6.8)	– 1.5
19	Haiti (6.3)	– 1.5
21	Uruguay (2.9)	– 0.6
22	Argentina (3.1)	– 0.3



INDUSTRIALIZED COUNTRIES

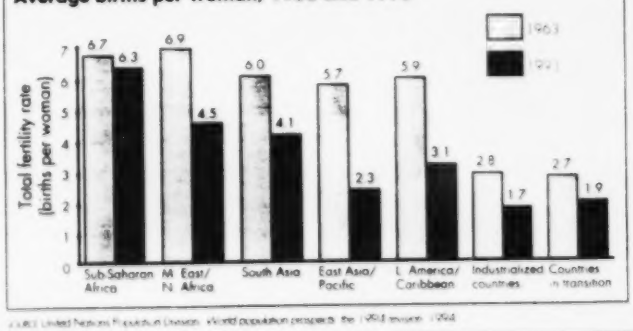
		Births
1	Ireland (4.0)	– 1.9
2	Spain (2.9)	– 1.7
3	Canada (3.5)	– 1.6
4	Netherlands (3.1)	– 1.5
4	New Zealand (3.7)	– 1.5
4	Portugal (3.1)	– 1.5
7	Australia (3.2)	– 1.3
7	Austria (2.8)	– 1.3
9	Germany (2.5)	– 1.2
9	Italy (2.5)	– 1.2
11	France (2.8)	– 1.1
11	United States (3.2)	– 1.1
▶	*Regional average*	*– 1.1*
13	Belgium (2.6)	– 1.0
13	Norway (2.9)	– 1.0
13	United Kingdom (2.8)	– 1.0
16	Denmark (2.6)	– 0.9
16	Israel (3.8)	– 0.9
16	Switzerland (2.5)	– 0.9
19	Greece (2.2)	– 0.8
20	Finland (2.5)	– 0.6
21	Japan (2.0)	– 0.5
22	Sweden (2.3)	– 0.2

COUNTRIES IN TRANSITION

		Births
1	Azerbaijan (5.6)	– 3.1
2	Albania (5.7)	– 2.9
3	Turkmenistan (6.7)	– 2.7
3	Uzbekistan (6.6)	– 2.7
5	Bosnia/Herz. (3.7)	– 2.1
6	Macedonia (3.9)	– 1.9
7	Armenia (4.4)	– 1.8
7	Kazakhstan (4.3)	– 1.8
9	Kyrgyzstan (5.4)	– 1.7
10	Tajikistan (6.3)	– 1.4
11	Moldova (3.1)	– 1.0
11	Slovakia (2.9)	– 1.0
13	Belarus (2.6)	– 0.9
13	Russian Fed. (2.4)	– 0.9
15	Georgia (2.9)	– 0.8
15	Slovenia (2.3)	– 0.8
▶	*Regional average*	*– 0.8*
17	Bulgaria (2.2)	– 0.7
17	Poland (2.6)	– 0.7
19	Lithuania (2.4)	– 0.6
19	Romania (2.1)	– 0.6
19	Yugoslavia (2.6)	– 0.6
22	Croatia (2.2)	– 0.5
22	Ukraine (2.1)	– 0.5
24	Czech Rep. (2.2)	– 0.4
25	Estonia (1.9)	– 0.3
26	Latvia (1.8)	– 0.2
27	Hungary (1.8)	– 0.1

Dwindling families

Average births per woman, 1963 and 1993



SOURCE: United Nations Population Division, World population prospects: the 1994 revision, 1994.

Halved in one generation

Countries with a fertility rate of 6 or over in 1963 which had halved births by 1993

	Average births per woman		
	1963	1993	% fall
Thailand	6.4	2.1	67
Colombia	6.7	2.7	60
Dominican Rep.	7.3	3.1	58
Kuwait	7.3	3.1	58
Tunisia	7.1	3.1	56
Costa Rica	6.8	3.1	54
Brazil	6.1	2.9	53
Mexico	6.7	3.2	52
Lebanon	6.3	3.1	51
Peru	6.8	3.4	50
Venezuela	6.6	3.3	50

WORLD AVERAGE

Fall in births per woman 1963 - 1993

FAMILY PLANNING ACHIEVEMENT AND

The recent Demographic and Health Surveys in 47 countries have yielded a much more detailed picture of women's struggle to gain control over child-bearing.

In almost all nations, women are marrying later, delaying the start of child-bearing, and having fewer children in total.

But the surveys also show that most women want fewer children still, and that many want to postpone their next pregnancy. And although contraceptive use has risen sharply, there is still a large unmet demand for family planning.

Bangladesh – 24% of women do not want pregnancy but are not using contraception

The unmet need for family planning

About a quarter of all women want to stop having children or to postpone the next pregnancy for at least two years, but are not using contraceptives.

Such women are defined by DHS surveys as having an 'unmet need' for family planning.

Unmet need does not necessarily mean that family planning services are not available. It may also mean that women lack information, or that the quality of the services on offer does not inspire the necessary confidence, or that women themselves have little say in the matter.

Nonetheless, where family planning services are considered to be strong – as in Brazil, Sri Lanka, Thailand, or Viet Nam – unmet demand is less than 15%. In eight of the sub-Saharan African countries surveyed, unmet need rises to between 30% and 42%.

The level of unmet demand says little about either overall demand or the level of contraceptive use. In both Botswana and Uganda, for example, unmet demand is estimated at 27%: but in Botswana the overall demand is 60% of which 33% is met, whereas in Uganda the overall demand is 32% of which only 5% is being met.

The measure of need

Percentage of currently married women aged 15-49 who want to stop having children or to postpone the next pregnancy for at least two years, but who are not using contraception

Sub-Saharan Africa			
Niger	18	Zambia	27
Nigeria	20	Burkina Faso	29
Cameroon	21	Mali	33
Namibia	21	Madagascar	34
Zimbabwe	23	Kenya	32
Guinea	25	Malawi	34
Burundi	26	Liberia	35
Botswana	27	Rwanda	36
Senegal	27	Ghana	37
Tanzania	27	Togo	42
Uganda	27		
Asia, the Middle East and North Africa			
Viet Nam	11	Tunisia	20
Thailand	12	Jordan	23
Turkey	12	Bangladesh	24
Sri Lanka	13	Philippines	26
Indonesia	14	Pakistan	27
Egypt	20	Sudan	27
Morocco	20	Nepal	28
Latin America and the Caribbean			
Brazil	14	Bolivia	24
Colombia	15	Ecuador	25
Peru	16	Mexico	27
Dominican Rep	17	Trinidad/Tobago	27
Paraguay	20	Guatemala	30
El Salvador	22		

Downsizing

In every country surveyed by the DHS, women's views on 'ideal family size' are changing. In almost half of the 20 nations for which data are available, women want at least one child fewer than they did 10 to 15 years ago.

The chart compares recent DHS findings with the World Fertility Surveys (WFS) of a decade or so earlier. Kenya shows the biggest change: in 1977, women said the ideal family size was 7.2 children; in 1993 the answer to the same question produced an average of 3.9.

Family planning does not seem to be keeping pace. In all but one of the 47 nations covered by the latest surveys, women say their desired number of children is less than today's average – usually by at least one child.

Women's views on ideal family size may reflect the expectations or pressures of husbands, family elders, and communities.

The ideal size

Desired number of children among currently married women aged 15-49

	Years between surveys	WFS surveys	DHS surveys
Sub-Saharan Africa			
Kenya	15	7.2	3.9
Ghana	8	6.1	3.5
Senegal	15	6.4	5.3
Cameroon	13	6.0	7.3
Asia, the Middle East and North Africa			
Egypt	12	4.1	2.8
Thailand	12	3.7	2.8
Sri Lanka	12	3.8	3.1
Philippines	15	4.4	3.5
Tunisia	10	4.2	3.5
Morocco	12	5.0	3.9
Pakistan	16	4.2	4.1
Jordan	15	6.3	4.4
Sudan	11	6.4	5.9
Latin America and the Caribbean			
Peru	14	3.8	3.7
Colombia	14	4.1	2.8
Trinidad/Tobago	10	3.8	3.1
Dominican Rep	16	4.7	3.3
Ecuador	7	4.2	3.4
Mexico	10	4.5	4.2
Paraguay	11	5.3	4.4

DISPARITY

Kenya – one of the leaders in Africa's fertility fall, but 28% are mothers by 18

Many are mothers at 18

There is still one country – Niger – where half of all women give birth before the age of 18. In 17 other countries surveyed by the DHS programme, mainly in Africa, more than a quarter of all girls become pregnant before the age of 18.

The maternal death rate is three times higher for teenage mothers than for women in the 20-29 age group. Teenage pregnancy also tends to close off opportunities for education and training.

The younger a woman is when she first gives birth, the longer her total child-bearing period and the more children she is likely to have. This, too, increases the risks to the life and health of both mothers and children.

Many countries set a lower minimum age of marriage for females than for males. In 6 of the 21 sub-Saharan African countries surveyed, the median age at marriage was less than 18. In Bangladesh, Guinea, Mali, Niger, and Yemen, more than half of the young women interviewed were married by the time they were 16 years old.

According to the International Women's Rights Action Watch: "*There are a number of reasons to insist that girls not be married until they are a sufficient age to make an informed choice. The first is that as a matter of basic human right no person should undertake such a momentous act without full knowledge of its import, and no child can understand the full social and physical import of marriage. Another is that child-bearing at too early an age can severely damage a girl's reproductive and general health, causing such problems as obstructed labour, sometimes bleeding to death, and vesico-vaginal fistula, leading to social ostracism as well as health problems.*"

Proportion of women aged 20-24 years at time of survey who had their first birth by age 18

	% aged 20-24 mothers by 18		% aged 20-24 mothers by 18
Niger	53	Bolivia	19
Guinea	49	Indonesia	19
Mali	47	Namibia	18
Cameroon	46	Dominican Rep	17
Liberia	44	Pakistan	17
Uganda	42	Sudan	17
Malawi	38	Ecuador	16
Nigeria	35	Paraguay	16
Senegal	34	Egypt	15
Zambia	34	Colombia	13
Burkina Faso	32	Trinidad/Tob	13
Madagascar	31	Peru	12
Togo	30	Turkey	11
Guatemala	28	Thailand	9
Kenya	28	Rwanda	8
Tanzania	28	Burundi	8
Yemen	27	Jordan	8
Botswana	26	Philippines	8
Zimbabwe	25	Morocco	7
Ghana	23	Sri Lanka	5
Mexico	22	Tunisia	3
		Viet Nam	3

Birth and marriage

Median age at first marriage and at first birth among women aged 25-29

	Median age first married	Median age at first birth
Sub-Saharan Africa		
Rwanda	21	22
Burundi	20	21
Namibia	*	21
Ghana	19	20
Madagascar	19	20
Nigeria	17	20
Tanzania	19	20
Zimbabwe	19	20
Botswana	25	19
Burkina Faso	18	19
Cameroon	17	19
Kenya	20	19
Liberia	18	19
Malawi	18	19
Mali	16	19
Senegal	17	19
Togo	18	19
Uganda	18	19
Zambia	18	19
Guinea	16	18
Niger	15	18
Asia, the Middle East and North Africa		
Morocco	19	25
Sri Lanka	23	25
Tunisia	23	25
Jordan	21	23
Philippines	22	23
Sudan	21	23
Thailand	21	23
Viet Nam	21	23
Egypt	20	22
Turkey	20	22
Pakistan	19	21
Indonesia	19	20
Yemen	16	20
Bangladesh	15	18
Nepal	17	–
Latin America and the Caribbean		
Colombia	23	23
Brazil	21	22
Dominican Rep	20	22
Paraguay	21	22
Peru	22	22
Trinidad/Tobago	20	22
Bolivia	21	21
Ecuador	20	21
Mexico	20	21
Guatemala	19	20

UNICEF & FAMILY PLANNING

UNICEF has long viewed the responsible planning of family size, especially birth spacing, as an essential part of maternal and child health (MCH) services. While containing rapid population growth is generally the central concern of most family planning advocates, UNICEF sees the primary objective of child spacing as bringing about an improvement in the survival, well-being and quality of life of the child, the mother and the family.

In 1994, the Cairo International Conference on Population and Development made it clear that family planning programmes must be part of a wider approach to improved child survival, safe motherhood and reproductive health.

That wider approach – including increasing women's control over their own lives, working for gender equality, and improving levels of women's health and education – demands the efforts of many United Nations organizations and specialized agencies, and involves a broad division of labour between them.

As a matter of policy, approved by its Executive Board, UNICEF does not advocate any particular method of family planning, believing this to be a matter best decided by people themselves in accordance with their needs, values and preferences. As a matter of practice, UNICEF does not provide contraceptive supplies. UNICEF has never provided support for abortion and it continues to be the long-standing UNICEF policy not to support abortion as a method of family planning.

However, as part of its mandate for improving the well-being of children and women, UNICEF is actively involved in advocacy and practical action for the reduction of under-five mortality and maternal mortality, for the support of breastfeeding, for the education of girls and raising the age of marriage, and for supporting women in their multiple roles. All of these make a major and direct contribution towards the integrated approach to family planning and population issues.

In particular, UNICEF continues to advocate the well-informed timing and spacing of births, and to draw attention to the well-documented disadvantages for both mother and child of births that are 'too close or too many' and to mothers who are 'too young or too old'.

CHILD RIGHTS

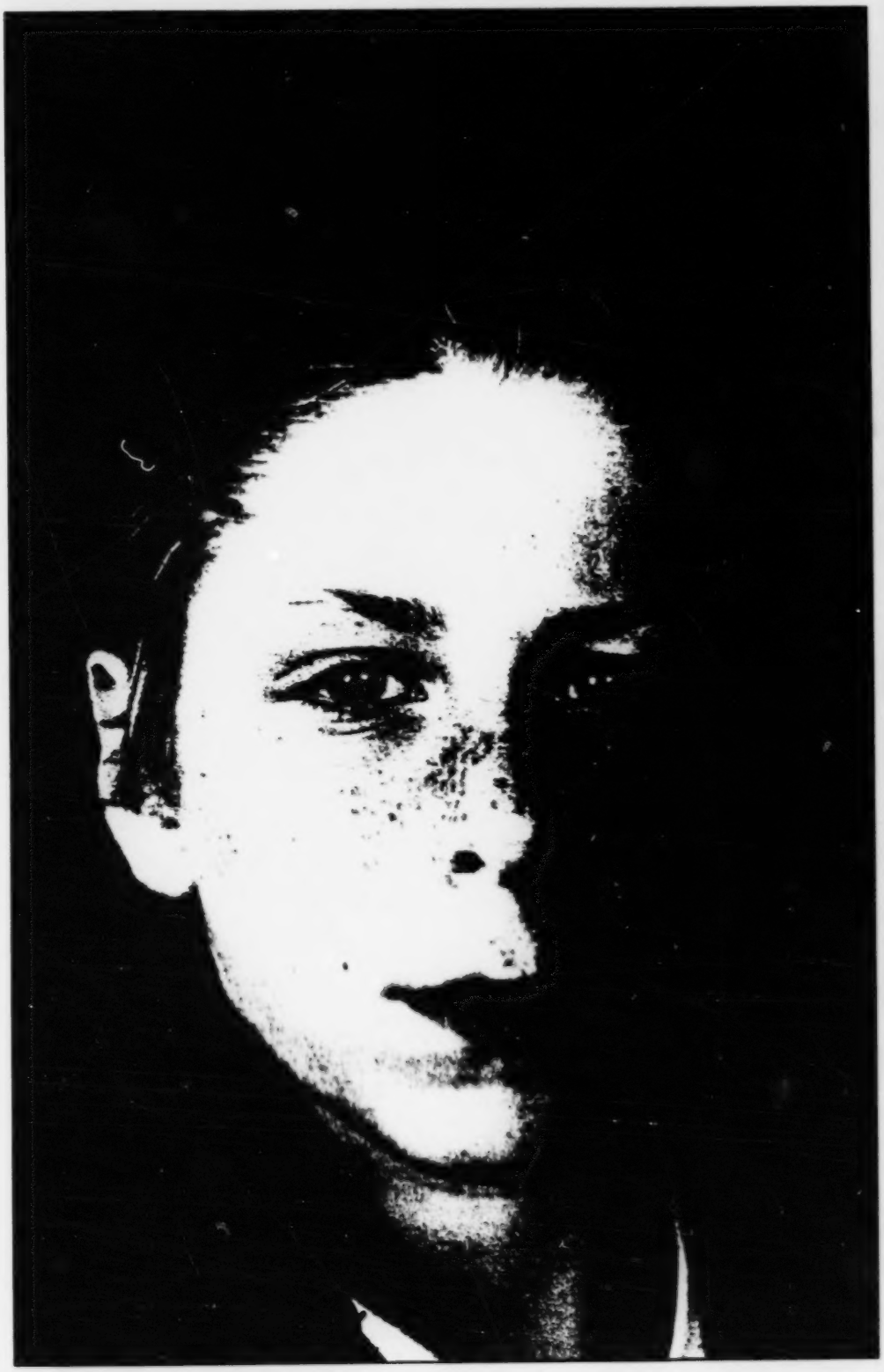
COMMENTARY

In only five years, the Convention on the Rights of the Child has been ratified by 174 countries.*

But children continue to be neglected and abused in many of the countries whose governments have solemnly set their seal on the Convention.

Hoda Badran, Chairperson of the Committee on the Rights of the Child, argues that ratification is a statement of intent rather than of fact – a promise that governments must now begin to live up to.

*As at mid-April 1995



BEST COPY AVAILABLE

A conventional approach

Hoda Badran

Hoda Badran, Professor of Social Research and Community Participation at the University of Helwan, Cairo, is the current Chairperson of the International Committee on the Rights of the Child. The Committee was established by the United Nations to monitor the progress of the Convention.

The 1989 Convention on the Rights of the Child has now been ratified by 174 of the world's nations – making it the most widely and rapidly accepted Convention in human rights history.

Some have pushed for rapid ratification by all countries to provide a universally accepted 'moral platform' from which to defend children's rights. Others have argued that the 'rush to ratify' devalues the Convention because neglect and abuse are still common in many ratifying countries.

Ratifying countries are obliged to report to the 10-member Committee on the Rights of the Child – of which I am currently the chairperson – detailing the steps being taken to put the Convention into practice.

Well, say the critics, all this certainly creates jobs for bureaucrats, produces prodigious amounts of paperwork, and provides endless excuses for meetings, but what does it offer to the millions of children in the world who are malnourished, uneducated, abused, prostituted, exploited?

Statement of intent

Loud and passionate public protest against violations is essential. There should be more of it. Public outcry, nationally and internationally, is one of the few powerful and immediate ways of protecting children's rights.

But the Committee on the Rights of the Child has a different job to do.

Rightly or wrongly, it makes the assumption that by ratifying the Convention a government is making a serious statement of intent. Our purpose is to help governments live up to that promise.

This means meeting with governments – usually Ministers, Deputy Ministers, Attorneys-General, and Members of Parliament or Congress – to discuss the situation of children in their country. We examine the facts on health, nutrition and education, and we look for the internal disparities that are often more revealing than national averages. We also look closely at institutional arrangements, national legislation, and juvenile justice systems.

We do not rely solely on governments; we also consult with non-governmental organizations.

The Committee then issues its concluding observations.

In the unfailingly polite language of the diplomatic world, those observations begin with 'positive aspects'. We *"note with satisfaction"* that Viet Nam has passed new laws on the Protection, Care and Education of Children, or that Egypt has established a National Council for Childhood and Motherhood.

Each report then turns to 'points of concern'. In the case of Bolivia, for example, we noted *"the disparities ... based on race, sex, language, and ethnic or social origin."* In the case of the Russian Federation, *"we are concerned that society is not sufficiently sensitive to the needs of the disabled."*

We also express our 'deep concern' over the continuance of child labour, child prostitution, the failure to protect children in armed conflicts, and the breadth and depth of discrimination against girls. And we point out repeatedly that culture and tradition are not acceptable reasons for violations of a Convention which now stands as an internationally agreed minimum standard for children everywhere.

Violations

Polite, yes. Uncritical, no. Assisted by the four lawyers on the Committee of 10, we look closely at each nation's legislation. We point out that a lower minimum age of marriage for girls than for boys is discriminatory (violating article 2 of the Convention). Or we cite cases where juvenile offenders are not separated from adults (violating article 37). Perhaps most important of all, we remind governments that the Convention on the Rights of the Child includes not just civil and political rights but also the rights to adequate nutrition, primary health care, and a basic education – *"to the maximum extent of their available resources."*

A process that works

Finally, we make specific recommendations. We recommend that country x may wish to study what has been done in country y, or that training courses should be organized for the staff in juvenile correctional facilities. In the case of the Sudan, for example, the Committee *"expressed the hope that the review of child-related laws will result in the total abolition of flogging"* (the Government responded by announcing that this practice would be ended).

Where possible, we also identify sources of help – from the United Nations system, from aid programmes, or from voluntary organizations.

This is an unspectacular, even bureaucratic process. But it is aimed at bringing change inside national establishments – in national institutions, national plans, national legal systems, national policies.

This is our cause. And however passionately we may feel as individuals about issues that come before us, it is a cause that would not be advanced if we merely directed the finger of accusation.

We have seen enough in five years to know that this approach works. When the Government of Viet Nam, for example, accepted that we were more interested in helping than criticizing, they submitted an open and self-critical report. Subsequently, Viet Nam acted: laws covering the protection, care, and education of children have all been passed.

Submissions from 174 countries, so far, must be reviewed in this way by a Committee that is already falling behind in its work. Its 10 elected members – lawyers, academics, civil servants, social workers – spend three months of each year on the Committee's business. But without more institutional support – to research its concerns and publicize its findings – the Committee will be unable to maintain effective dialogue with governments. This is yet another example of the international community wishing to be seen to be taking action on human rights while not being prepared to provide the institutional resources to make that action effective.

The child rights Committee is only one of the tools needed in the struggle to engrave the Convention into the conscience of nations. But its reports have a special place in that struggle. For they assess each nation's performance against a universal standard to which the government is already committed. With the help of the public and the non-governmental organizations, the media and the professional bodies, these reports should become a powerful means of increasing public pressure, monitoring the progress of the Convention, and protesting its violations.

Five years after making its first report to the child rights Committee, each country must submit a second report on the changes made. The first of those five-year reports will soon fall due. Nation by nation, they will be a revealing guide as to whether or not the promise is being kept.

As yet, there is no place for cynicism about the Convention on the Rights of the Child. There is only a crying need for wider public involvement in forcing the pace down the long road from universal ratification to universal implementation.

Current members of the Committee on the Rights of the Child are:
Hoda Badran (Egypt)
Akila Belembaogo (Burkina Faso)
Flora Corpuz Eufemio (Philippines)
Thomas Hammarberg (Sweden)
Judith Karp (Israel)
Yuri M. Kolosov (Russian Federation)
Sandra Prunella Mason (Barbados)
Swithun Tachiona Mombeshora (Zimbabwe)
Marta Santos Pais (Portugal)
Martha Sardenberg Zelner Goncalves (Brazil)

CHILD RIGHTS

ACHIEVEMENT AND

The Convention on the Rights of the Child is a universally agreed standard for the care and protection of children.

The formal progress of the Convention – including the processes of ratification, reporting, and the lodging of reservations – provides an early indication of how seriously it is being treated by the world's governments.

These pages list those governments that have not yet ratified the Convention, and those that are late in reporting on the practical steps taken to implement its provisions.

The Convention – a minimum standard for the care and protection of children

Convention covers 99% of world's children

Almost 99% of the world's children now live in countries whose governments have committed themselves to the international Convention on the Rights of the Child.

Since it was adopted by the General Assembly of the United Nations just over five years ago, the Convention has been ratified by 174 nations. The governments of 6 more countries have signed the document – indicating their intention to ratify. Only 11 nations have neither signed nor ratified. Several of those are expected to do so before the end of the year.

Human rights conventions have usually taken several decades to become widely accepted. At the 1993 World Conference on Human Rights, it was proposed that all nations should aim to ratify the Convention on the Rights of the Child by the end of 1995.

Some countries have indicated that they have no objection to the Convention but wish to make sure that they are in compliance with all its provisions before ratifying. Most other governments have regarded ratification as a declaration of intent rather than of fact. The Government of India, for example, has ratified the Convention but indicated that it intends to *"take measures to progressively implement"* article 32, dealing with child labour.

The 6 countries that have signed but not ratified

Haiti*	Swaziland
Liechtenstein	Switzerland
South Africa	United States

The 11 that have neither signed nor ratified

Andorra	Singapore
Brunei Darussalam	Somalia
Kiribati	Tonga
Oman	Tuvalu
Palau	United Arab Emirates
Saudi Arabia	

* Ratification since completion mid-April 1995

Ex cathedra

James P. Grant, Executive Director of UNICEF from 1980 until his death in January 1995, persuaded many heads of state to sign the Convention on the Rights of the Child. To see the Convention universally ratified was one of his greatest ambitions, and the failure to sign of his own country, the United States, was one of his greatest frustrations.

From his hospital bed on the day before his death, Jim Grant wrote to President Clinton urging that the Convention be signed by the US before the end of 1995.

On February 10th 1995, at a memorial service held for Jim Grant in the Cathedral of Saint John the Divine, New York, First Lady Hillary Clinton paid the one tribute he would have wanted:

"One of his great hopes was that the Convention on the Rights of the Child would serve as a statement of principle that would guide us into the next century. Therefore I am pleased to announce that the United States will sign the Convention on the Rights of the Child. This morning the President instructed Secretary of State Christopher to take the necessary steps to that effect."

Six days later, on February 16th 1995, the United States formally signed the Convention on the Rights of the Child.

SOURCES: (all ratification and reporting details for the Convention on the Rights of the Child) United Nations Office of Legal Affairs and United Nations Centre for Human Rights, mid-April 1995

Not by government alone

The Convention on the Rights of the Child specifically invites the involvement of non-governmental organizations (NGOs). Taking up the challenge, NGOs in 22 countries have submitted alternative reports to those provided by their governments.

In the United Kingdom, the Child Rights Development Group enlisted the support of over 150 voluntary organizations in drawing up its report. Timed to coincide with the publication of the Government's official report, the 350-page alternative report was presented to the Committee on the Rights of the Child in Geneva and attracted unprecedented media attention for child rights in the UK.

The Committee on the Rights of the Child welcomes NGO participation and urges governments to consult with relevant national NGOs before drawing up their reports.

DISPARITY

Peru – one of 10 nations to report on time

Most nations late reporting

Governments ratifying the Convention on the Rights of the Child are obliged to report within two years to the Committee of 10 experts set up to monitor the Convention (see article page 29). The reports are meant to detail the steps being taken to comply with the Convention.

An early indicator of whether governments are taking the Convention seriously is whether their reports are submitted on time – or at all.

As at end February 1995, 21 nations are more than a year overdue. A further 35 are over two years late submitting their reports.

The table at right shows the full record of the 132 governments due to have reported by March 1995.

Coming soon?

Reports due March - December 1995

Algeria	Libya	St Vincent/G
Armenia	Marshall Is	Suriname
Antigua/B	Micronesia	Syria
Comoros	Monaco	Tajikistan
Congo	Morocco	Turkmenistan
Fiji	N Zealand	Vanuatu
Greece	Papua N G	
Liberia	St Lucia	

Reports due during 1996

Afghanistan	Iraq	Mozambique
Eritrea	Japan	Nauru
Gabon	Kazakhstan	Samoa
Georgia	Kyrgyzstan	Uzbekistan
Iran	Luxembourg	

Reports due during 1997

Botswana	Netherlands	Solomon Is
Malaysia	Qatar	Turkey

Reports now submitted

Reports submitted on time

Bolivia	Myanmar*	Sudan
Denmark	Peru	Sweden
Ireland	Rwanda	Viet Nam
Jordan		

Reports submitted up to 6 months late

Argentina	El Salvador	Pakistan
Belarus	Germany	Romania
Canada	Indonesia	Russian Fed
Colombia	Madagascar	Tunisia
Costa Rica	Mexico	Ukraine
Egypt	Namibia	UK Kingdom

Reports submitted over 6 months late

Belgium	Italy	Poland
Burkina Faso	Jamaica	Spain
Chile	Korea, Rep	Sri Lanka
France	Norway	Tanzania
Honduras	Paraguay	

Reports submitted over 1 year late

Croatia	Lebanon	Philippines
Cyprus	Maldives	Portugal
Finland	Nicaragua	Yemen
Holy See	Niger	Yugoslavia

Reports submitted over 2 years late

Guatemala	Mongolia	Senegal

Reports not yet submitted

Up to 6 months overdue

Austria	Cameroon	Ireland
Azerbaijan	Czech Rep	** Moldova
Cambodia	India	Slovakia

More than 6 months overdue

Albania	Cape Verde	Latvia
Bahrain	China	Lesotho
Bosnia/Herz	Eq Guinea	Thailand
C African Rep		

More than 1 year overdue

Bahamas	Ethiopia	Mauritania
Bulgaria	Hungary	Nigeria
Côte d Ivoire	Israel	San Marino
Cuba	Kuwait	Sao Tome/P
Dominica	Lao Rep	Slovenia
Dominican Rep	Lithuania	Trinidad/T
Estonia	Macedonia	Zambia

More than 2 years overdue

Angola	Gambia	Nepal
Australia	Ghana	Panama
Bangladesh	Grenada	St Kitts/Nevis
Barbados	Guinea	Seychelles
Belize	Guinea-Bissau	Sierra Leone
Benin	Guyana	Togo
Bhutan	Kenya	Uganda
Brazil	Korea, Dem	Uruguay
Burundi	Malawi	Venezuela
Chad	Mali	Zaire
Djibouti	Malta	Zimbabwe
Ecuador	Mauritius	

Iraq – some reservations on the Convention

One third of governments lodge reservations

About one third of the 174 countries that have ratified the Convention on the Rights of the Child, as at mid-April 1995, have done so while lodging reservations with the Secretary-General of the United Nations, thereby stating their intention not to be bound by certain of its provisions.

In some cases, reservations have been lodged by governments who do not think that the Convention goes far enough: Uruguay, for example, has stated that it would have been better for the Convention to stipulate 18 rather than 15 as the minimum age for participation in armed conflict.

More controversial are reservations which seem to allow wholesale exemptions from the Convention. The Governments of such nations as Djibouti, Iran, Kuwait, Mauritania, Pakistan, and Syria, for example, have reserved the right not to apply any articles in the Convention that are *"incompatible with the laws of Islamic shariah."*

The Holy See has similarly declared that *"the application of the Convention should be compatible in practice with the particular nature of the Vatican City State and of the sources of its objective law."*

The Committee on the Rights of the Child (see article page 29) regularly asks governments to withdraw reservations, pointing out that the whole purpose of the Convention is to establish a universally applicable minimum standard for the care and protection of children. In the case of reservations lodged by Islamic Governments, The Committee also point out that a number of Islamic nations participated in the redrafting of the Convention to ensure compatibility with the Islamic shariah. This led to Egypt's becoming one of the first 20 countries to ratify, and to the Organization of the Islamic Conference calling on all its members to ratify the Convention.

In some cases, governments have also deposited 'declarations' to define positions on particular issues. Argentina, for example, has said that it understands *"child"* to mean *"every human being from the moment of conception up to the age of 18,"* whereas the United Kingdom has declared that it *"interprets the Convention as applicable only following a live birth."* China, France, and Luxembourg have all said that they do not consider their existing family planning policies to be incompatible with article 6 on the child's right to survival.

THE CONVENTION:

Most of the world's governments have ratified the Convention on the Rights of the Child. Now the challenge is to move from universal acceptance to universal observance.

In all regions of the world, children continue to be malnourished, to be plagued by preventable disease, to be denied even a basic education. They continue to be exploited, prostituted, and abused in the home, at work, and in war.

These pages set out some of the worst and most widespread violations of the Convention on the Rights of the Child.

NPGs - a measure of the Convention

The Convention on the Rights of the Child is the first human rights agreement to include basic economic and social rights. All ratifying countries are obliged *"to diminish infant and child mortality"* and to *"combat disease and malnutrition."* The Convention also calls upon nations to make sure that all children have access to education.

Obviously it is easier for richer nations to meet these obligations, and the Convention caters for this by declaring that countries *"shall undertake such measures to the maximum extent of their available resources."*

This of course is difficult to measure. How can parents and citizens know if their government is attempting to meet these basic social rights to the best of its resources?

The basis of such judgements must be international comparison. A country cannot claim that it is meeting basic needs to the maximum extent of its available resources if far poorer countries are doing much better. A country with a child death rate of 250 per 1000 births or a malnutrition rate of 30%, for example, cannot claim that this is entirely due to poverty if lower rates have been achieved by much poorer countries.

It has been obvious for some time that some nations have achieved levels of child well-being – whether measured by survival, nutrition, or educational attainment – that are far higher than in other countries at a similar economic level.

For the past three years, *The Progress of Nations* has systematized such comparisons by calculating the average level of child well-being (as measured by such indicators as the under-five mortality rate, the malnutrition rate, and the percentage of children who reach grade 5 of primary school) for any given level of economic development (as measured by per capita GNP).

For each indicator and each country, the gap between the actual level and the average level is termed the national performance gap (NPG). NPGs can, of course, be positive or negative.

Despite inadequate statistics, the NPG provides an approximate measure of how well each country is doing for its children in relation to its resources. It is therefore a measure of Article 4 of the Convention on the Rights of the Child – monitoring whether nations are meeting their children's rights for survival, nutrition, and education *"to the maximum extent of their available resources."*

The tables on this page show some of the worst NPGs in child survival, nutrition, and education. NPGs for all countries can be found on pages 50 to 51.

The Convention also calls for the basic rights of children to be met *"within the framework of international cooperation."* A long-standing part of that framework is the agreement that the industrialized nations should give 0.7% of GNP in official development assistance. The difference between actual aid levels and the 0.7% of their GNP aid target is therefore also a measure of the 'performance gap' of the industrialized nations (listed on page 46).

Malnutrition

Countries where the percentage of children malnourished is more than 10 points higher than the average for that country's level of economic development (per capita GNP)

	% of under-fives malnourished		
	Actual	Expected	Gap
India	69	31	-38
Bangladesh	66	35	-31
Mauritania	48	24	-24
Papua New Guinea	35	19	-16
Guatemala	34	19	-15
Indonesia	40	25	-15
Sri Lanka	38	23	-15
Malaysia	23	10	-13
Pakistan	40	27	-13
Philippines	34	21	-13
Namibia	26	15	-11

Survival

Countries where the under-five mortality rate is more than 30 points higher than the average for that country's level of economic development (per capita GNP)

	Under-five deaths per 1000 live births		
	Actual	Expected	Gap
Niger	320	148	-172
Liberia	217	114	-103
Mauritania	202	106	-96
Sierra Leone	284	191	-93
Mali	217	141	-76
Zambia	203	127	-76
Malawi	223	162	-61
Central African Rep	177	123	-54
Ghana	170	118	-52
Nigeria	191	139	-52
Turkey	84	35	-49
Namibia	79	37	-42
Turkmenistan	89	48	-41
Senegal	120	83	-37
South Africa	69	32	-37
Bolivia	114	79	-35
Burkina Faso	175	141	-34
Cameroon	113	79	-34
Iraq	71	38	-33
Brazil	63	31	-32
Yemen	137	105	-32
Algeria	68	37	-31

Education

Countries where the percentage of children reaching grade 5 of primary school is more than 20 points lower than the average for that country's level of economic development (per capita GNP)

	% reaching grade 5		
	Actual	Expected	Gap
Haiti	12	52	-40
Gabon	50	87	-37
Dominican Rep	41	75	-34
Guatemala	41	75	-34
Afghanistan	13	46	-33
Guinea	26	58	-32
Angola	34	65	-31
Brazil	56	85	-29
Bhutan	9	35	-26
Mali	22	47	-25
Niger	23	45	-22
Burkina Faso	26	47	-21
Colombia	59	80	-21
El Salvador	58	79	-21

For a full list of national performance gaps – in survival, nutrition, and education – see pages 50 to 51.

VIOLATIONS

Pakistan – male literacy 46%, female 21%

Where female literacy is half

Progress towards gender equality is discussed elsewhere in *The Progress of Nations* (pages 36 to 41). But it should be recorded here that the most pervasive violation of the rights of the child in the modern world is the consistent subordination of girls.

Gender inequality is evident in virtually every country, rich or poor. But inequality in education is particularly important because it undermines the struggle for equality in almost all other fields.

Inequality in literacy

The 18 countries where twice as many men as women are literate

	Adult literacy 1990		Ratio men to women
	% men	% women	
Afghanistan	42	11	×3.8
Burkina Faso	26	7	×3.7
Niger	18	5	×3.6
Nepal	37	11	×3.4
Sierra Leone	40	14	×2.9
Liberia	49	18	×2.7
Mozambique	52	19	×2.7
Guinea	45	18	×2.5
Burundi	45	19	×2.4
Gambia	48	20	×2.4
Benin	42	19	×2.2
Bhutan	51	23	×2.2
Pakistan	46	21	×2.2
Senegal	39	19	×2.1
Bangladesh	47	23	×2.0
Djibouti	55	27	×2.0
Morocco	52	26	×2.0
Togo	61	30	×2.0

Denied the right to walk the earth

The right of the child to special protection in armed conflicts is being violated every day by the estimated 100 million land-mines that adults have planted in the soils of at least 62 countries.

With a 'shelf life' up to 50 years, mines indiscriminately destroy limbs, lives and livelihoods. Fertile farmland is left uncultivated, roads abandoned, and water sources made unsafe.

Children are particularly vulnerable to the mines, most of which are triggered by pressure, even the light weight of a child, or by a trip-wire. Some kill or maim by explosive force, others spew metal fragments.

Afghanistan – with 9 to 10 million mines – has the distinction of being the world's most heavily mined country. Angola, with about 9 million, is a close second. Cambodia, where the 12-year civil war has left the countryside littered with 4 to 7 million mines, comes third in the lethal league table.

More than 362 types of land-mine are currently made in 55 countries.

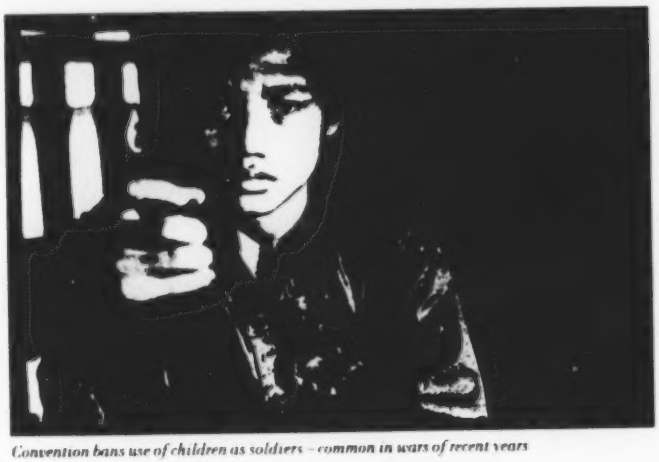
Mines moratoriums

Fifteen countries so far have announced comprehensive export moratoriums on anti-personnel land-mines.

Argentina	Italy
Belgium	Poland
Canada	Slovakia
Czech Rep	South Africa
France	Spain
Germany	Sweden
Greece	United States
Israel	

In addition, the Netherlands and Switzerland have banned exports to states that are not adherents to Protocol II (the land-mine section) of the Convention on Conventional Weapons.

The Russian Federation and the United Kingdom have imposed an indefinite moratorium on the export of anti-personnel land-mines that do not self-destruct or self-neutralize.



Convention bans use of children as soldiers – common in wars of recent years

The war on children

Most of the casualties of modern wars are not soldiers but civilians – a high proportion of them children. In the last decade, an estimated 2 million children have been killed in armed conflicts. Perhaps 4 to 5 million more have been disabled, and more than 12 million made homeless.

Many more millions have been traumatized by the atrocities they have been forced to witness or take part in.

The Convention on the Rights of the Child calls on governments to take special measures to protect children in the event of armed conflict. It also bans the use of children as soldiers – common practice in several of the wars of recent years including those in Afghanistan, Iran, Iraq, and Mozambique.

Statistics on children affected by war are scarce. The Office of the United Nations High Commissioner for Refugees (UNHCR) estimates that approximately 23 million men, women, and children across the world have left their homelands to escape persecution and violence.

In addition, there are an estimated 26 million 'internal refugees' who have been forced to leave their homes but who have not crossed national boundaries.

In the refugee populations for which relevant data are available, the proportion of under-18s is regularly more than 50%.

To and from

Nearly half of the world's estimated 23 million refugees have fled from just five countries. Other UNHCR surveys of refugee and displaced populations in 13 countries show that half or more are under 18.

From:	Afghanistan	2,800,000
To:	Iran	1,600,000
	Pakistan	1,200,000
From:	Rwanda	2,000,000
To:	Zaire	1,100,000
	Tanzania	600,000
	Burundi and others	300,000
From:	Liberia	846,000
To:	Guinea	450,000
	Côte d'Ivoire	360,000
	Ghana	16,000
	Sierra Leone	16,000
	Nigeria	4,000
From:	Somalia	510,000
To:	Ethiopia	240,000
	Kenya	170,000
	Yemen and others	80,000
	Djibouti	20,000
From:	Former Yugoslavia	3,700,000
To:	Bosnia	2,700,000
	Serbia	405,000
	Croatia	380,000
	UN protected areas	122,000
	Macedonia and Slovenia	49,000
	Montenegro	44,000

There are few accurate statistics on two of the worst and most widespread violations of children's rights – child prostitution and child labour.

The number of under-18s involved in prostitution probably exceeds 2 million. Best estimates suggest a figure of 1 million for Asia alone – and 300,000 for the United States.

ILO data for 124 nations indicate a total of nearly 80 million children under 15 involved in child labour. The total for all nations may be double that figure.

Young girls work as prostitutes in a poor area of the Nicaraguan capital, Managua

The ultimate abuse

Article 34 of the Convention on the Rights of the Child calls on all countries to prevent *"a) the inducement or coercion of a child to engage in any unlawful sexual activity; b) the exploitative use of children in prostitution or other unlawful sexual practices; and c) the exploitative use of children in pornographic performances and materials."*

Likened by some to torture in the depth of the damage and trauma it inflicts, the sexual exploitation of children is one of the gravest infringements of rights that children can endure.

Like child labour, it is everywhere. It runs the sordid gamut from incest and sexual abuse by friends and family members to the enforced, servile marriage of the too-young girl, to the systematic commercial plundering of children and young teenagers in lucrative prostitution and pornography markets.

Even in those countries with well-developed law enforcement systems, the organized abuse of children still flourishes. An estimated 300,000 young people below the age of 18 are involved in prostitution in the United States, and child prostitution and pornography are significant problems in parts of Europe and the Russian Federation.

Few children, even those running away from unhappy and violent homes, readily become prostitutes. Many are kidnapped, sold by relatives, or tricked into brothel captivity by promises of legitimate employment. Girls employed as domestic servants may become prostitutes after enduring years of sexual abuse by their employers. Many are transported far from their homes, and some to other countries, where they are isolated by language and their illegal status. Coercion, intimidation, violence, drugs and degradation are used to compel submission.

The physical toll is horrendous, exposing children to the risk of pregnancies and sexually transmitted diseases. AIDS is a deadly reality for many. In Thailand, one study found that a third of the children involved in prostitution tested HIV-positive.

Local customers may have created the trade, but growing numbers of tourists from industrialized countries are now travelling to the developing world for the purpose of sexually exploiting children.

A review of 160 foreigners arrested in Asia for sexual abuse of children between 1992 and 1994 showed the accused to be 25% American, 18% German, 14% Australian, 12% British, and 6% French. Australia, Denmark, France, Germany, Japan, Norway, Sweden and the United States now have laws permitting the prosecution of their citizens for sex crimes against children committed outside their countries.

Action to control the sexual exploitation of children has begun on several fronts.

In the Philippines, a 1991 law targets the adult procurers, brothel owners, and abusers of children. Several communities have also created volunteer patrols to monitor bars and brothels for the presence of children.

In India, the Domestic Workers' Movement offers legal protection, education and counselling to its members, many of whom have been sexually abused.

In Recife, Brazil, the *Casa de Passagem* programme offers drop-in facilities, residential care, counselling and job opportunities for girls living on the streets.

Interpol's Standing Working Party on Offences against Minors shares information between police forces on known paedophiles.

One non-governmental organization, End Child Prostitution in Asian Tourism (ECPAT), has been particularly effective in agitating for political action and legal reform. The organization now intends to campaign against child 'sex tourism', not just in Asia but worldwide.

There are few reliable figures for the numbers of children involved in prostitution. The following estimates, for a limited number of countries only, serve to illustrate the scale of the problem.

Guesstimates

All estimates are for children under 18 except Bangladesh, which covers children aged 12 to 16.

Bangladesh	10000
Cambodia	2000
India	400000 - 500000
Pakistan (children from Bangladesh)	40000
Philippines	60000
Sri Lanka	30000
Thailand	100000
United States	300000
Viet Nam*	8000

VIOLATIONS

Some work from 6 in the morning until 7 at night for less than 20 cents a day

Children pay high price for cheap labour

Millions of children work to help their families in ways that are neither harmful nor exploitative. But millions more are put to work in ways that drain childhood of all joy – and crush the right to normal physical and mental development.

This is the kind of work that the Convention on the Rights of the Child seeks to end. Article 32 sets out the right *"to be protected from economic exploitation and from performing any work that is likely to be hazardous or to interfere with the child's education, or to be harmful to the child's health or physical, mental, spiritual, moral or social development."*

By and large, it is the children of marginalized communities, their futures already threatened by inadequate diet and health care, who are at greatest risk from exploitation at work. In India, the majority of children in servitude are children from low castes or tribal minorities. In Latin America, the highest incidence of child labour is found among the indigenous people.

Often such children are as young as six or seven years old. Often their hours of labour are 12 to 16 hours a day. Often their place of work is the sweatshop, the mine, the refuse heap, or the street. Often the work itself is dull, day-long, repetitive, low-paid or unpaid. Sometimes the child works under the threat of violence and intimidation, or is subject to sexual exploitation.

In the 1990s, child labour has found a new niche in the rapidly expanding export industries of some developing countries. In one small carpet factory in Asia, children as young as five were found to work from 6 in the morning until 7 at night for less than 20 cents a day. In another, they sat alongside adults for 12 to 14 hours in damp trenches, dug to accommodate the carpet looms on which they wove. In a garment factory, nine-year-olds worked around the clock sewing shirts for three days at a stretch, permitted only two one-hour breaks, during which they were forced to sleep next to their machines. Extracting such high human cost, child labour is nevertheless cheap. A shirt that sells in the United States for $60 can cost less than 10 cents in labour.

Such labour takes an enormous toll on children, in stunted intellectual and physical development, in chronic lung diseases, in ruined eyesight and bone deformations, and sometimes in death.

Those who survive pay a high price in lost development, often passing that price on to their own children, forging the shackles of poverty, ignorance and servitude across the generations.

No one knows how many children labour around the world. Clear data are not available. Some of the most widespread forms – domestic service, agricultural and bonded labour – are largely invisible to surveys and statistics. Yet enough studies have now been done to indicate the scale of the problem.

In India, between 5% and 30% of the 340 million children under the age of 16 are estimated to fall under the definition of child labour. In Africa, over 20% of children are thought to be economically active. In Latin America, the proportion is estimated between 10% and 25%.

Child labour can be ended, and the right of the child to be protected from exploitation can be enforced, by new laws, by enforcing existing laws, by media pressure, and by enrolling more children in school.

Following media exposure, for example, consumer boycotts of Asian carpets in European countries have begun to bite. A child-labour-free trademark should soon be appearing on the carpets produced by Indian manufacturers that meet the requirements of the Rugmark Foundation – an organization whose members include non-governmental organizations (NGOs), representatives of the German Export Promotion Council, UNICEF, and owners of Indian carpet companies. Participating industries have agreed to allow monitoring of their factories at regular intervals – and spot checks by NGOs.

Ultimately, it is the meeting of another basic right – the right to education – that can do most to protect the child from economic exploitation. Children cannot be abused in fields or factories if they are sitting in classrooms. And it is, above all, increasing school enrolment and retention that will withdraw millions of children from the workforces of the world.

Unfortunately, the children most likely to be exploited are those who are hardest to reach with conventional schooling (see article page 19).

Labour list

The following table lists estimates that have been made for child labour in the nations with the largest under-16 populations.

China (347 = under 16s)	No data
India (340 = under 16s)	
Ministry of Labour, 28/7/1989	17.5 million
Baroda Operation Khadak Group (1993)	44.0 million
Bangalore Centre for Concerted Action against Labour, 1992 (Number children out of school)	100.0 million
Indonesia (64 = under 16s)	
ILO, 1992 Ages 10-14	2.3 million
Population census, 1990 Ages 10-14	2.2 million
UNICEF, 1994 Ages 10-14	2.7 million
Pakistan (62 = under 16s)	
Pakistan Labour Force Survey 1990/1991 Ages 10-14	2.0 million
ILO, 1993 Bonded child labour	1.5 million
Pakistan Institute of Development Economics, 1994 Under 15s	12.0 million
United States (61 = under 16s)	
National Safe Workplace Institute 1993 Ages 12-17	5.3 million
Brazil (55 = under 16s)	
Brazilian Institute for Geography and Statistics, 1994 Ages 10-13	2.0 million
UNICEF, 1994	7.0 million
Nigeria (50 = under 16s)	
UNICEF, 1994	12.0 million
Bangladesh (44 = under 16s)	
Bangladesh Bureau of Statistics 1990 Ages 10-14	5.7 million
ICFTU, 1993	15.0 million
Mexico (35 = under 16s)	
ILO, 1993 Ages 12-14	1.3 million
Mexican Statistics Institute 1994 Under 15s	11.0 million
Russian Fed. (35 = under 16s)	No data
Iran (31 = under 16s)	No data
Viet Nam (29 = under 16s)	No data
Philippines (27 = under 16s)	
Philippine Department of Labor and Employment, 1991 Ages 10-17	2.2 million
Philippine Department of Labor and Employment, 1994	5.0 million
Egypt (25 = under 16s)	
ILO, 1991 Under 15s	0.4 million
Government survey, 1994 Ages 6-14	1.4 million

Note: Years of surveys are given in roman type, years of citation in italic type.

Sources:

1 International Labour Organization, *1994 yearbook of labour statistics*, 1995.

2 Bureau of International Affairs, US Department of Labor, *By the sweat and toil of children: the use of child labour in American imports*, report to Congress, 15 July 1994.

3 United Nations Commission on Human Rights, *Rights of the child: sale of children, child prostitution and child pornography*, E/CN.4/1994/84, report by Special Rapporteur, 14 January 1994.

4 International Labour Organization, *World labour report 1992/1993*.

5 International Federation of Chemical, Energy and General Workers Unions, *Social health, safety and the environment*, no. 1, 1993.

Under 16s: United Nations, *World population prospects, the 1992 revision*, 1994.

PROGRESS FOR W

COMMENTARY

In September 1995, the Fourth World Conference on Women will convene in Beijing.

In last year's edition of The Progress of Nations, Conference Secretary-General Gertrude Mongella wrote about the changes required in education, in health and family planning, in law, and in technology, to advance the struggle towards gender equality.

This year, Frene Ginwala, Speaker of the South African National Assembly, writes about the importance of women in parliaments – and of what they do when they get there.

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Discrimination not the problem

Frene Ginwala

Frene Ginwala, MP, is the Speaker of the South African National Assembly. A barrister, Ms. Ginwala headed the research department of the African National Congress (ANC) and its Commission for the Emancipation of Women. After leaving South Africa as a student to help arrange the escape of the late ANC President Oliver Tambo, she completed her studies at the universities of London and Oxford before returning to Africa to become managing editor of Tanzania's principal English-language newspaper. In 1990, she returned to South Africa to help establish the ANC Women's League. Ms. Ginwala has published several books on apartheid and on gender issues.

A year ago, we shed tears for the waste of the past and the joy of the future as blacks and whites in South Africa went to the polls for the first free elections in our country's history.

The attention of the world was focused on the election of a multiracial parliament, and on the spectacle of white generals saluting a black President whom they had held prisoner for most of the previous 30 years.

But when the dust settled, it was also noticed that 100 of the 400 members of the new National Assembly were women.

Many have been impressed by the fact that this is a greater percentage than many long-standing democracies, and considerably higher than the United States or the United Kingdom.

The women who are in that parliament are perhaps less surprised and less impressed; less surprised because we have been working for some time to integrate the emancipation of women into the liberation struggle; and less impressed because we do not choose to compare ourselves with the US or the UK but with countries like the Nordic nations which, as the tables on the following pages of *The Progress of Nations* show, are leading the way towards equal representation. Like them, we believe that 25% is but halfway.

Women's movement

We also believe that increasing the number of women in parliament is not an end in itself. It is not only a matter of equity or justice or good democratic practice. The point of having more women MPs is that women bring different experiences, perceptions and priorities to the decision-making process—which leads to different decisions being made. Informed by both male and female experience, the decisions are likely to be more appropriate for the entire population.

For political decisions to be shaped by women's experience, those women who have broken through into positions of political leadership must retain their links with the women's movement. It is easy to let those ties be loosened. With many different issues to address, committees to attend, speeches to make, it is tempting to say, "Oh well, I won't talk about women on this occasion." And soon the links weaken, the roots shrivel.

The responsibility does not rest only with MPs. The women's movement must claim its women in parliament, it must demand from them that they speak out at every opportunity, and that the positions and decisions they take are informed by women's experience. Where we come from is not enough. It's whether where we're going is still connected to where we come from that matters.

In the case of South Africa, the good start that has been made towards greater representation in parliament is largely the result of the strong women's movement that has been built up over recent years.

In 1991, when it became clear that a new South Africa was fast approaching, women from across the divides of race, religion, class, and political parties came together out of a common concern that the transformation of society should not proceed without us, and without addressing our concerns. The result was the Women's National Coalition, and its aim was to entrench the principle of gender equality in the new Constitution. In the process, hundreds of thousands of women from all walks of life were consulted about the changes they wanted to see in the new South Africa. The result was our Charter of Effective Equality.

In many ways, the experience of South Africa's women has been similar to the experience of women elsewhere. But it is an experience that has been intensified, thrown into more dramatic relief, by apartheid.

Apartheid and gender

Apartheid was gender specific. It moved African men to the urban, industrial, and mining areas, forcing women to remain in the rural areas to care for the children, the old, the disabled, the sick, and the community. In this way, the role of women as the reproducers of labour was institutionalized.

Men were isolated from day-to-day family responsibility. Demoralized, many spent or drank their wages, sending back little or nothing to wives and families and in many cases setting up new homes in the cities. Far from being dependent on male breadwinners, women therefore headed millions of homes across the country. Their earnings were not supplemental. They were essential for family survival.

Such women learned to cope. Many managed their lives alone and against great odds. Even though many were still subject to customary law, which treated women as minors, they were able to manage their day-to-day lives.

But the reality of their legal status caught up with them. Many, for example, would sell chickens or food from home. Because they were women, they had no access to the credit which small businesses need to expand. Many is the woman who has sought out her husband in some urban area to ask him to take out a loan for her, only to find that the money is spent before it reaches her, and that she must lose the business she had hoped to expand because its assets were pledged as security for the loan.

All of this means that women in South Africa are very aware of the need for independence and equality. Under apartheid, many have become acutely conscious and resentful of the patriarchal order. This is not a theory to them. They do not need the theory. They need freedom. And they see the creation of a new South Africa as an opportunity to mobilize for an end to the patriarchal order.

Women in many countries today will recognize this experience. As migration for work becomes more common, and as traditional social structures break down, more and more households are headed by females, and more and more women are having to struggle and cope alone. In both industrialized and developing worlds, we are seeing a feminization of poverty.

In South Africa, because of apartheid, women have become acutely aware of the patriarchal society. But because of apartheid, also, they have experienced a kind of independence. Millions of women have run their own lives, their own families, their own homes, and their own communities. They have coped and managed over many years and against great odds. And at this new dawn, they do not take kindly to the assumption that men alone should manage their lives or their country.

Inequality

The concept of discrimination implies that the problem is a system which is generally acceptable but which unfairly excludes particular groups. If a golf club or a holiday resort excludes Jews or blacks, for example, then the problem is one of discrimination, and the solution is to end that discrimination by admitting all groups under the existing systems and rules. The problem is in the

COMMENTARY

"We have refused all attempts to pose female emancipation as a social problem that can somehow be separated from political and economic realities. We have refused to accept that this is a struggle for women's rights in isolation, and insisted that it is a much more fundamental struggle for political, economic, and social liberation without which equal rights can only bring a relatively superficial change for a relatively small number....

The women's struggle is not just a struggle to transform the position of women in society but a struggle to transform society itself."

exclusion from a given structure, not in the structure itself.

Yet when discrimination against women is ended – when the laws that exclude women are repealed – the problem for women does not go away. Across the world there are countries where discriminatory laws have been repealed and where women can, in theory, function as equal citizens. Yet women do not, in practice, have equal opportunity – in educational systems, in professions, or in parliaments. They do not enjoy equality in decision-making, for self-development, for learning new skills, for leisure and experiment, for branching out in new directions, or for exercising their legal rights.

The reason for this persistence of inequality, even when discrimination has been ended, is that the systems into which women are being admitted are themselves skewed and distorted. In a word, they are man-shaped. They have been structured by and for males, based on male experience, male perceptions, male priorities, and male belief that the natural order of society is patriarchal. We should not, therefore, be surprised when entry into such systems does not result in equality for women.

Again, it is the apartheid years that have sharpened our understanding of this difference between discrimination and inequality. It took time to learn that apartheid was not a system which discriminated against blacks and to which blacks should be admitted. It took time to realize that the whole institution of apartheid was designed and built around assumptions about white and black and the predetermined relationship between them. And when in the 1980s a few doors were opened to a few blacks, most recognized that this was not a solution to our problems but merely a means of co-option into an unacceptable system.

Similarly, we need to understand that the subordinate status of women in society arises not from discrimination within a structure that we wish to join but from the inbuilt oppression of a structure that we wish to change.

In short, the institutions that discriminate are man-shaped and must be made people-shaped. Only then will women be able to function as equals within those institutions, and only then will all women be able to bring their own experience and their own perceptions to the decisions that must be taken.

Merely opening the doors to the existing system is not enough. In some Western countries the women's movement has, I believe, focused too much on equal opportunity, on opening the door, rather than on what happens once the door is opened.

Assumptions

Transforming structures is of course more difficult than gaining admission to them. Often, those structures are built on gender-based assumptions that are so deeply embedded in our societies that they are taken, by many women as well as men, to be a part of the natural order, a part of the landscape rather than a man-made edifice built upon gender oppression.

There is the assumption, for example, that women should function in the private domain of home and family while men should operate in the public domain of economic and political life. Then there are the related assumptions that the male is the breadwinner, while the female is the home-maker, and that labour expended within the home does not add value and therefore deserves no share of recompense while labour outside the home does add value and should be paid accordingly. Many aspects of our lives and our societies are structured in one way or another around these related assumptions – including our educational systems and our employment and promotion criteria.

To take one small example, parliament in South Africa follows the British tradition of meeting in the afternoon and continuing on into the evening – to allow men to spend the morning at the stock market or in offices or law chambers. It was assumed that they had no family responsibilities, and could return home at an unspecified time later in the evening knowing that the thousand small daily tasks of living and looking after families would have been taken care of. Is it any wonder that women, when admitted to such institutions, find it difficult to function as equals within them?

Opening doors into a male world is therefore not the issue. And so long as we treat the problem of inequality as one of discrimination there will be no real solution. A minority of women will be invited or allowed into the man-shaped world. A few will even succeed there. But for women as a whole, little will have changed.

For the same reasons, the struggle for equality should not be diverted into the cul-de-sac of women's rights. Women's rights are no different from men's. And for most women the issue is not rights but the ability to exercise those rights.

The intensifying discussion of human rights over recent years has been, in the main, a male-dominated discussion. And it has tended to ignore the fact that equal rights are almost meaningless if large numbers of women are unable to exercise those rights because of the cumulative consequences of gender oppression.

In particular, it is revealing that the human rights debate has largely ignored the question of reproductive rights. Yet for millions of women, reproductive rights are fundamental to their health and well-being, to their opportunities and freedoms, to their control over their own bodies and their own lives, and hence to their exercise of almost every other right.

Rights

Rights in constitutions and the law, by themselves, have limited relevance to the women who must work the treble shift of caring for children, managing homes, and earning incomes; or to the women who lack skills, training, education, and confidence; or to the women who are committed to 20 years of child-bearing without the option; or to women who are subject to intimidation and violence; or to women who face inaccessible and gender-insensitive judicial systems.

Such inequalities both arise from and contribute to the structural subordination that prevents women from exercising their rights. And unless this issue of structural subordination is faced, equal rights will be little more than a hollow slogan for the great majority of the world's women.

One of the most important of the contributions that the women of the developing world have made to the women's movement over recent years is that we have refused all attempts to pose female emancipation as a social

problem that can somehow be separated from political and economic realities. We have refused to accept that this is a struggle for women's rights in isolation, and insisted that it is a much more fundamental struggle for political, economic and social liberation without which equal rights can only bring a relatively superficial change for a relatively small number.

In South Africa, for example, we have applied this argument to our Bill of Rights, which is part of our interim Constitution. I would like to see written into the new Constitution the need to focus on the *delivery of effective equality* – to enable women to claim and exercise their rights. I would like to see some kind of parallel document that would be formally attached to the Bill of Rights in order to oblige people to be aware of the concept of structural subordination. Judges, politicians, civil servants, and administrators would be obliged to consult such a charter whenever they made decisions – so that they are informed about what is required in order to provide equality and human rights for women.

A different development

Changing institutions rather than merely gaining admittance, delivering effective equality rather than simply legislating for human rights, and revivifying the processes of participation to ensure that women's experience informs decision-taking – all of these are at the centre of the women's struggle. Together, these changes add up to the transformation of society rather than just the transformation of women's position within that society. This is what we mean by saying that the end result of increasing women's participation in politics must be a different and a better product.

Delivering effective equality for women, for example, implies changing the current pattern of development. It means reaching out to and responding to the needs of the poor, a majority of whom are women, far more effectively and consistently than political systems have shown themselves capable of doing in the past. It means, for example, a new emphasis on the achievement of economic growth through increasing the productivity of the poor majority in general and the poor majority of women in particular. And it means emphasizing the kind of labour-intensive economic activity that most directly assists families to meet their needs for adequate food, clean water, safe sanitation, primary health care, and decent housing. Strengthening these most basic of social services – all of them labour-intensive and best managed in a participatory way – would help to meet the needs and liberate the time and energies of millions of women. At the same time, it would create employment and invest in both human well-being today and economic capacity tomorrow. It is the intention of our Reconstruction and Development Programme that these basic, liberating investments would be funded not by borrowing without thought to the future but by restructuring expenditures around new priorities and by attracting foreign aid in support of these goals.

Similarly, the task of bringing the experience and perceptions of women to bear on the reshaping of society means a different and a better democracy. Too many of our male-dominated political parties have become little more than electoral machines. Too many of our male-dominated elections have become little more than the manipulation of images. Too many of our democracies have become little more than voting rituals. These crises, part and parcel of the alienation of people from political decisions, are common to most democracies. And the struggle to open up political processes to women through the devising of effective means of participation is an opportunity to revivify democracy itself.

To some, this will seem a far cry from the issue of female representation in parliaments. But it is the logical conclusion of seeing the women's struggle not as a struggle to transform the position of women in society but as a struggle to transform society itself. ■

"Millions of women in South Africa have run their own lives, their own families, their own homes, and their own communities. They have coped and managed over many years and against great odds. And at this new dawn, they do not take kindly to the assumption that men alone should manage their lives or their country."

Photo: UNICEF/Cindy Indrein

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PROGRESS FOR W

LEAGUE TABLE OF

The nations of the world are ranked here according to the proportion of women elected to their parliaments.

Where politicians are freely elected by universal franchise, the proportion of women representatives is an indicator of changing attitudes in society at large.

Worldwide, only 1 elected politician in 9 is a woman. In the face of such marked inequality, it is not possible to be satisfied with the speed of progress.

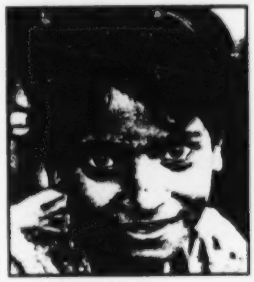
Yet only half a century ago, women did not even have the vote in most nations – including such economically advanced nations as France and Japan.

SUB-SAHARAN AFRICA

		%
1	South Africa	25
2	Rwanda	17
2	Uganda	17
4	Chad	16
4	Eritrea	16
4	Mozambique	16
7	Guinea-Bissau	13
8	Cameroon	12
8	Senegal	12
8	Zimbabwe	12
11	Tanzania	11
12	Angola	10
12	Burundi	10
14	Ghana	8
▶	*Regional average*	*8*
15	Namibia	7
15	Zambia	7
17	Benin	6
17	Burkina Faso	6
17	Gabon	6
17	Liberia	6
17	Malawi	6
17	Niger	6
23	Botswana	5
23	Côte d'Ivoire	5
25	Central African Rep.	4
25	Madagascar	4
25	Zaire	4
28	Kenya	3
28	Mauritius	3
30	Lesotho	2
30	Mali	2
32	Congo	1
32	Ethiopia	1
32	Togo	1
35	Mauritania	0
	Guinea	NO PARLIAMENT
	Nigeria	NO PARLIAMENT
	Sierra Leone	NO PARLIAMENT
	Somalia	NO PARLIAMENT

MIDDLE EAST and NORTH AFRICA

		%
1	Iraq	11
2	Algeria	7
2	Tunisia	7
4	Sudan	5
5	Iran	4
▶	*Regional average*	*3*
6	Egypt	2
6	Lebanon	2
6	Turkey	2
9	Jordan	1
9	Morocco	1
9	Yemen	1
12	Kuwait	0
12	U. Arab Emirates	0
	Libya	NO DATA
	Syria	NO DATA
	Oman	NO PARLIAMENT
	Saudi Arabia	NO PARLIAMENT



SOUTH ASIA

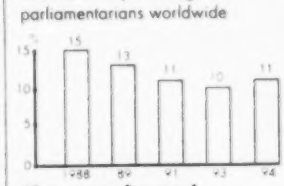
		%
1	Bangladesh	10
2	India	7
3	Sri Lanka	5
▶	*Regional average*	*5*
4	Nepal	3
5	Pakistan	2
6	Bhutan	0
	Afghanistan	NO PARLIAMENT

Countries ranked by % of women in parliament

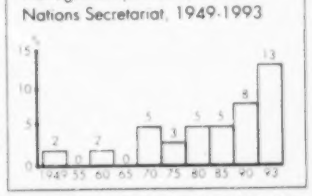
Decline in 1990s

The total number of MPs in the world (single and lower chambers) is 34,306, of whom 3,737, or 11% are women. This proportion is influenced by the higher rates in some countries with large parliaments, such as China's with its total membership of nearly 3,000. When rates instead of numbers are tallied, the world average slips to 9%. There are still a few countries – including Bahrain, Kuwait, and the United Arab Emirates – where women can neither stand for election nor vote. Women have recently been elected to parliament for the first time in Jordan (1 woman out of 80 MPs) and Morocco (2 out of 333).

One step backward
Women as a percentage of parliamentarians worldwide



Slow steps forward
Percentage of women in senior management positions, United Nations Secretariat, 1949-1993



United Nations, Human resources management report of the Secretary-General, 17 October 1994

WOMEN IN PARLIAMENT

EAST ASIA and PACIFIC

		%
1	China	21
2	Korea, Dem.	20
3	Viet Nam	19
4	Indonesia	12
5	Philippines	11
6	Lao Rep.	9
▶	*Regional average*	*9*
7	Malaysia	6
8	Cambodia	4
8	Mongolia	4
8	Singapore	4
8	Thailand	4
12	Korea, Rep.	1
13	Papua New Guinea	0
	Hong Kong	NO PARLIAMENT
	Myanmar	NO PARLIAMENT

SOURCE (for ranking tables and most statistics in these pages) Inter-Parliamentary Union, 'Distribution of seats between men and women in the 178 national parliaments existing as at 30 June 1994'. Reports and documents, no. 18, add. 2 – rev. 2, 1994

LATIN AMERICA and CARIBBEAN

		%
1	Cuba	23
2	Argentina	16
2	Nicaragua	16
4	Costa Rica	14
4	Trinidad/Tobago	14
6	Dominican Rep.	12
6	Jamaica	12
8	Colombia	11
8	El Salvador	11
▶	*Regional average*	*10*
10	Peru	9
11	Chile	8
11	Honduras	8
11	Mexico	8
11	Panama	8
15	Bolivia	7
16	Brazil	6
16	Uruguay	6
16	Venezuela	6
19	Ecuador	5
19	Guatemala	5
21	Haiti	4
22	Paraguay	3

INDUSTRIALIZED COUNTRIES

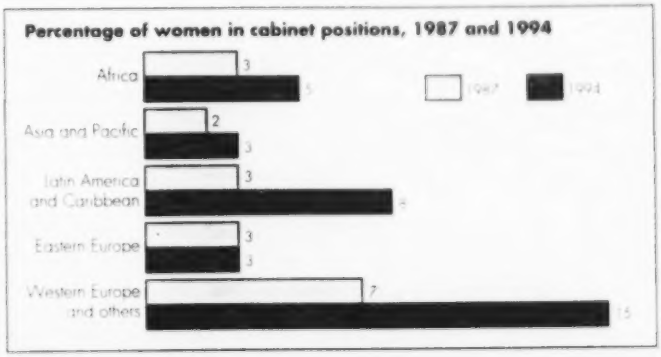
		%
1	Sweden	42
2	Finland	39
2	Norway	39
4	Denmark	33
5	Netherlands	31
6	Austria	21
6	Germany	21
6	New Zealand	21
9	Canada	18
9	Switzerland	18
▶	*Regional average*	*18*
11	Spain	16
12	Italy	15
13	Ireland	12
14	United States	11
15	Belgium	9
15	Israel	9
15	Portugal	9
15	United Kingdom	9
19	Australia	8
20	France	6
20	Greece	6
22	Japan	3

COUNTRIES IN TRANSITION

		%
1	Slovakia	18
2	Latvia	15
3	Estonia	14
3	Slovenia	14
5	Bulgaria	13
5	Poland	13
7	Hungary	11
7	Kazakhstan	11
9	Czech Rep.	10
9	Russian Fed.	10
9	Uzbekistan	10
▶	*Regional average*	*8*
12	Lithuania	7
13	Albania	6
13	Croatia	6
13	Georgia	6
13	Kyrgyzstan	6
17	Bosnia/Herzegovina	5
17	Moldova	5
17	Turkmenistan	5
20	Armenia	4
20	Belarus	4
20	Macedonia	4
20	Romania	4
20	Ukraine	4
25	Tajikistan	3
25	Yugoslavia	3
27	Azerbaijan	2

Women in cabinet

Only 62 of the world's 178 governements have any women in the cabinet. Worldwide, about 6% of cabinet positions are held by females – up from 3% in 1987. Most female cabinet ministers hold portfolios for social issues, health or education.



WORLD AVERAGE

% of MPs who are women

PROGRESS FOR W

ACHIEVEMENT ANI

While women slowly gain ground in politics, what progress can be reported for the great majority of women in the developing world?

These pages present some of the main findings of the Demographic and Health Surveys (DHS) programme – the most important recent source of information about the lives of women in the developing world.

With 47 nations surveyed so far, the DHS programme has conducted in-depth interviews with over 360,000 women over the last decade (the date of each country survey can be found on page 54).

Peru – average time spent with young children down from 17 years to 14

Fewer years spent with young children

Throughout much of the world, the lives of women are still largely circumscribed by motherhood. The average woman in sub-Saharan Africa, for example, has her first child at 19 and her last child when she is 38 or 39. About 25 years will therefore be spent with at least one child under the age of six years.

In Asia and Latin America, the average child-bearing period is usually shorter, but most women will still spend the first 10 or 15 years of their adult lives with primary responsibility for young children.

In almost all the countries surveyed by the DHS programme, the proportion of women's lives spent with young children has fallen since the World Fertility Surveys (WFS) of a decade earlier.

Looking after the young during their first few years – the years which see most of the growth of brain and body, of values and personality – is a demanding task made more demanding by poverty and lack of basic services. And for most women, it precludes the possibility of further education and training, or of working for change as opposed to working to maintain the status quo.

Women who look after young children have many other responsibilities, but few other opportunities.

The caring years

The number of years women aged 15-49 spend with at least one child under age six*

	Years between surveys	WFS surveys	DHS surveys
Sub-Saharan Africa			
Ghana	8	21	21
Senegal	15	21	20
Kenya	15	23	19
Asia, the Middle East and North Africa			
Jordan	11	18	16
Egypt	12	16	15
Morocco	12	17	15
Tunisia	10	17	14
Sri Lanka	12	13	11
Thailand	12	16	11
Latin America and the Caribbean			
Ecuador	7	17	16
Mexico	10	22	15
Peru	14	17	14
Colombia	14	15	12
Dominican Rep.	15	16	12
Trinidad Tobago	10	12	12

For a summary of DHS findings on progress for women in gaining control over child-bearing – see pages 26 to 27.

25% see child die

In 33 countries surveyed by DHS, at least a quarter of all mothers under the age of 50 have seen one or more of their children die. In four of the sub-Saharan African nations studied, more than half said that they had lost at least one child.

The major causes are pneumonia, diarrhoea, measles, tetanus, and malaria – five diseases which account for two thirds of illness and death among children in the developing world. Over half of the children who succumb to these diseases are weakened by malnutrition (see page 14).

In addition to the pain of losing a child, a woman may lose the contraceptive effect of breastfeeding – and so become pregnant again too quickly.

If parents cannot be confident of the survival of their children, they are less likely to be interested in family planning. Where child death rates are higher than 100 per 1000 births, contraceptive use generally remains below 20%.

The death of a child

Percentage of ever-married women aged 15-49 who have had at least one child die

	% having at least one child die		% having at least one child die
Niger	57	Guatemala	31
Mali	55	Kenya	30
Guinea	54	Morocco	30
Malawi	53	Pakistan	30
Burkina Faso	49	Zimbabwe	27
Liberia	47	Ecuador	26
Uganda	47	Indonesia	26
Rwanda	46	Namibia	26
Senegal	45	Tunisia	26
Burundi	43	Peru	25
Madagascar	43	Mexico	23
Togo	42	Turkey	23
Yemen	42	Botswana	22
Zambia	41	Brazil	20
Ghana	40	Jordan	20
Nigeria	40	Philippines	19
Tanzania	40	Dominican Rep.	18
Cameroon	38	Thailand	16
Sudan	38	Paraguay	15
Bangladesh	37	Colombia	13
Bolivia	35	Sri Lanka	13
Nepal	35	El Salvador	12
Egypt	32	Trinidad Tobago	10

DISPARITY

Sudan – percentage of women with no education almost halved in one generation

The generation gap

In 30 of the 47 countries surveyed by DHS, the percentage of women with no formal education has been more than halved in a single generation.

The biggest change has been seen in Jordan, Kenya, and Tanzania, where the proportion of women with some education has increased by 50 percentage points.

In seven countries – Burkina Faso, Burundi, Mali, Nepal, Niger, Pakistan and Yemen – at least three quarters of young women have no education at all. In four more countries – Bangladesh, Guinea, Morocco, and Senegal – over half of today's young women have no education.

Education for girls is widely regarded as 'the best single investment' that most developing countries could make. Female education is associated with more opportunities for women, better family health and nutrition, lower maternal and child death rates, and lower birth rates.

Generational change

	% women uneducated		
	Aged 45-49	Aged 20-24	% pt. rise in schooling
Tanzania	74	16	58
Jordan	63	6	57
Kenya	57	6	51
Rwanda	72	24	48
Togo	93	45	48
Cameroon	78	32	46
Viet Nam	60	14	46
Sudan	86	42	44
Tunisia	89	45	44
Ghana	74	31	43
Nigeria	85	42	43
Liberia	88	49	39
Uganda	67	30	37
Zambia	46	11	35
Morocco	89	55	34
Botswana	48	15	33
Indonesia	41	8	33
Bolivia	37	5	32
Malawi	72	42	30
Namibia	36	7	29
Madagascar	41	13	28
Turkey	45	17	28
Senegal	64	37	27
El Salvador	40	14	26

	% women uneducated		
	Aged 45-49	Aged 20-24	% pt. rise in schooling
Guinea	95	70	25
Mexico	30	6	24
Bangladesh	75	53	22
Yemen	99	77	22
Zimbabwe	28	7	21
Nepal	97	78	19
Ecuador	22	4	18
Guatemala	51	33	18
Burkina Faso	95	78	17
Peru	19	2	17
Mali	98	82	16
Thailand	21	6	15
Niger	99	85	14
Pakistan	89	75	14
Brazil	16	4	12
Egypt	60	48	12
Colombia	12	3	9
Burundi	87	79	8
Dominican Rep.	11	3	8
Sri Lanka	20	12	8
Paraguay	6	1	5
Philippines	4	2	2
Trinidad/Tobago	3	1	2

Half have no electricity

DHS surveys have also tried to build a picture of the day-to-day living conditions of women in developing countries by asking whether their homes have electricity, or dirt floors, or whether they have easy access to piped water.

Such indicators are especially important to women. In addition to their responsibilities for children, women are usually the ones who take care of the sick, cook the meals, wash the clothes, clean the houses, and fetch and carry the fuel and the water.

In general, the surveys found the domestic conditions were very much worse in sub-Saharan Africa, where about three quarters of households have no electricity. African women also have the largest number of children, the greatest burden of illness to cope with, and spend the most hours fetching wood and water.

Home front

Basic indicators of physical living conditions in 42 countries surveyed by the DHS programme. Dirt floors, and the lack of electricity and piped water, have a particular bearing on women's lives.

	% of homes with			Average of three indicators
	Electricity	Surfaced floors	Access piped water	
Sub-Saharan Africa				
Botswana	11	63	88	54
Namibia	27	47	57	44
Senegal	26	58	47	44
Ghana	26	69	11	42
Nigeria	27	50	35	37
Zambia	19	47	46	37
Cameroon	29	42	34	35
Guinea	26	39	25	30
Kenya	11	31	33	25
Madagascar	9	47	17	24
Tanzania	8	20	33	20
Burkina Faso	5	30	17	18
Malawi	3	13	25	14
Rwanda	2	11	22	12
Niger	5	13	15	11
Uganda	6	14	8	9
Mali	5	20	2	9
Zimbabwe	–	82	44	–
Togo	–	75	33	–
Burundi	–	5	13	–
Asia, the Middle East and North Africa				
Egypt	93	68	80	80
Philippines	66	93	37	65
Thailand	76	96	17	63
Morocco	49	71	55	58
Indonesia	49	69	15	44
Sri Lanka	23	59	18	33
Sudan	31	14	53	33
Bangladesh	18	10	5	11
Jordan	97	–	97	–
Turkey	–	91	71	–
Pakistan	61	–	35	–
Nepal	13	–	19	–
Latin America and the Caribbean				
Trinidad/Tob.	93	100	88	94
Colombia	91	90	89	90
Mexico	84	80	78	81
Ecuador	79	88	72	80
Dominican Rep.	78	89	67	78
Peru	70	63	72	68
Bolivia	64	55	62	60
El Salvador	62	56	61	60
Paraguay	58	68	36	54
Guatemala	48	45	61	51

Women's weekly

DHS surveys in over 30 countries asked women aged 15-49 if they read a newspaper at least once a week. Similar questions were asked about radio and television. Radio topped the list in 21 of the 33 countries, television in 8.

	% women who read newspaper weekly		% women who read newspaper weekly
Trinidad/Tobago	88	Indonesia	27
Ecuador	75	Egypt	25
Philippines	73	Tanzania	25
Paraguay	70	Morocco	22
Peru	69	Mexico	21
El Salvador	61	Tunisia	20
Sri Lanka	59	Malawi	19
Colombia	54	Dominican Rep.	16
Namibia	54	Madagascar	15
Brazil	45	Pakistan	14
Turkey	45	Senegal	13
Zambia	42	Jordan	11
Bolivia	41	Burkina Faso	8
Thailand	40	Yemen	8
Zimbabwe	40	Bangladesh	7
Kenya	31	Nepal	4
Guatemala	33		

AID

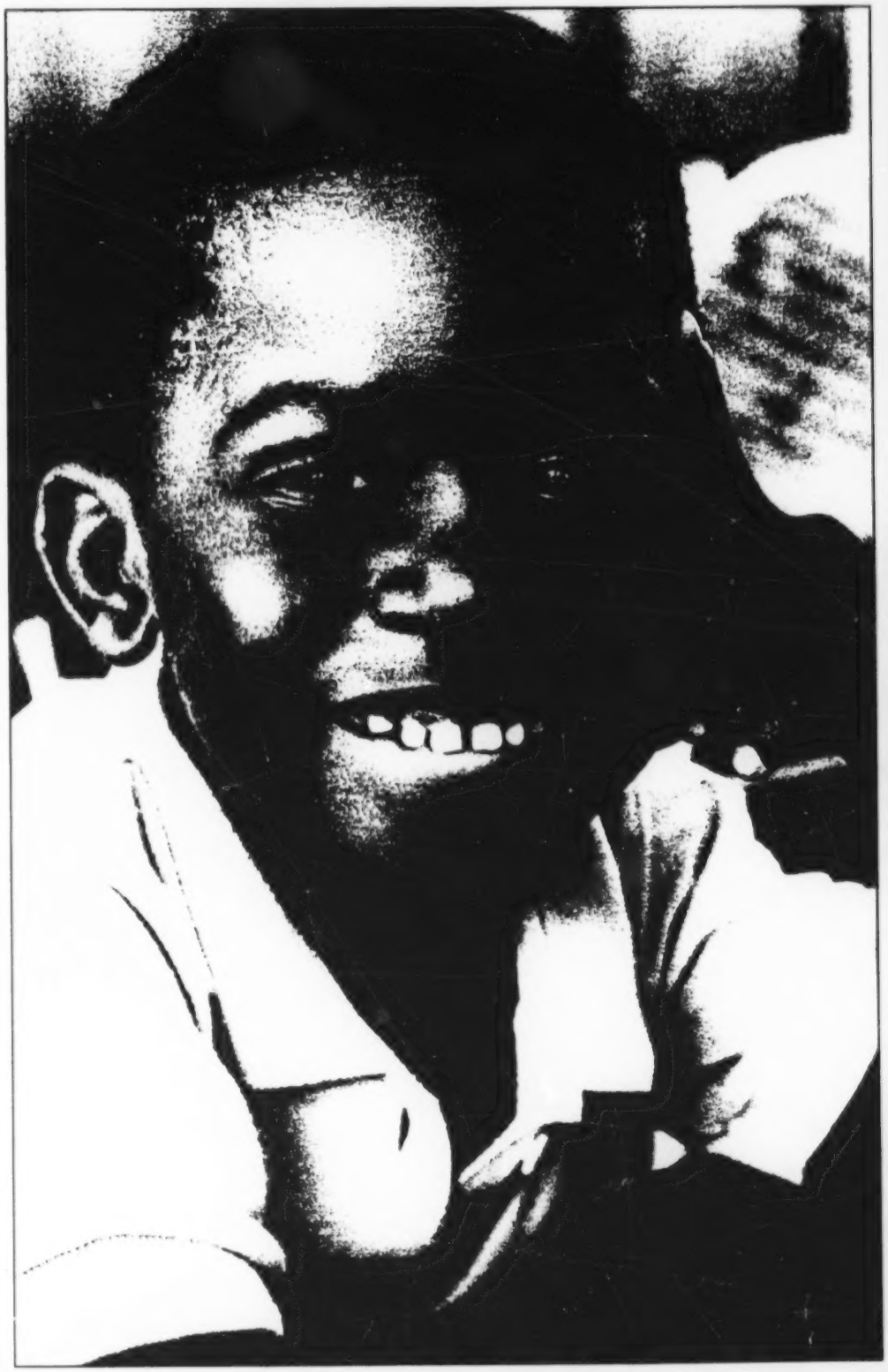
COMMENTARY

Even the countries that believe most strongly in free-market economics recognize the need for redistributive policies to prevent deepening inequality, to maintain the social fabric, and to invest in people's capacities.

Internationally, such policies are weak or non-existent.

Aid may not be the most important of the measures needed.

But as well as being indispensable to many of the poorest nations, it is a barometer of international concern for poverty and development.



A shameful condition

Gro Harlem Brundtland

Gro Harlem Brundtland is Prime Minister of Norway, one of the few industrialized nations that has regularly surpassed the 0.7% of GNP target for official development assistance (ODA). Ms. Brundtland headed the World Commission on Environment and Development which published its report, 'Our Common Future', in 1987.

The setting is my office in Oslo. The date is May 1st 1994. My visitor, UN Secretary-General Boutros Boutros-Ghali, speaks about the financial crisis of the United Nations, and asks: "Madam Prime Minister, how have you been able to keep up the high level of Norway's development assistance for so many years?"

This is, in our case, a one billion dollar question. Aid fatigue is felt in Scandinavia also, but we have managed even in times of financial constraint to maintain a high level of official development assistance (ODA), largely because most political parties have supported aid as a goal.

Aid for development was introduced in Norway in 1959 at a time when Norwegians felt that they were in a position to share their prosperity with people in what we then called the underdeveloped countries. Several other industrialized countries were able to expand their aid programmes during periods of growth and full employment. Then came the 1980s and the economic recession. Unemployment rates soared. People felt insecure. Never had the rich felt so poor.

Redistributive system

Scandals and stories of corruption in some recipient countries added to the problem of maintaining political support for aid. In recent years, environment considerations have entered the debate, and it became obvious that support for projects that were environment-friendly would be more easily forthcoming than for those that were not. Aid that was purely for the poor and hungry evaporated gradually. The 'CNN factor' might moderate this picture, but not for extensive periods of time.

I told the Secretary-General that friends from the third world had asked us to speak out more frankly about our aid programme – how 95% of it is not tied to Norwegian suppliers, how at least 4% goes to family planning programmes, and how it has been poverty oriented. I spoke also about how easy it is to criticize aid, and how difficult it is to come up with solutions that make it less needed.

We live in an inequitable world. But all our societies have some kind of social policy. Even the least developed and the most laissez-faire countries maintain some kind of redistributive system. And even if the opening up of free trade will provide enormous benefits, create businesses, and boost construction of infrastructure, there are sectors which depend more on responsibility and solidarity than on markets.

When speaking in the Guildhall of London in March 1994, the Prime Minister of India said that he knew of no great industrialist who would come and look after the primary health centres of India. That, he said correctly, was for the governments to do. Many countries not possessing the riches of India acknowledge this responsibility, but their means are even more limited.

A world where the vast majority of children are free from malnutrition, illiteracy and some of the most prevalent diseases could be achieved in a decade, if given priority. Nevertheless, we are approaching a new millennium without allocating the $30 billion a year which has been agreed as the cost for giving all children the chance to grow to their full physical and mental potential. This is an insignificant amount compared with the funds for military purposes.

The cost of poverty

From my own experience of working with the World Commission on Environment and Development, I would particularly emphasize how the cost of poverty, in human suffering, in the wasteful use of human resources, and in environmental degradation, has been grossly neglected. While only a minority of countries are welfare states in our Nordic sense of that word, the international redistributive system is in shameful condition.

It is not only the lack of generosity of donor countries that is to blame. The recipient countries are also responsible, because their governments have often failed to recognize that budgets for development aid in the North can only be carried by democratic support. The effective use of funds, and the social profile of the recipient nations, are relevant to the donors.

Basic programmes

A lot has been achieved in reaching the goals which were agreed on at the 1990 World Summit for Children. According to UNICEF's *The State of the World's Children 1995*, 2.5 million fewer children will die in 1996 than in 1990, because of increased efforts in primary health care. Guinea worm disease may soon be eradicated, and many regions are free from polio. Countries like Bangladesh, India, and Pakistan are now able to feed their populations. Even though it is difficult to estimate how many of these major achievements can be attributed to aid, they suggest that international cooperation can work.

More particularly, from infancy through adolescence, girls are in special need when it comes to nutrition, reproductive health and education. They will be the mothers and educators of tomorrow's children. As we agreed at the 1994 Cairo International Conference on Population and Development, the education of girls is the best of all strategies towards reproductive health and thereby reduction of birth rates, child mortality and the spreading of diseases such as AIDS.

The average level of ODA given by the donor countries in 1993 was 0.3% of GNP. Only about a quarter of this goes to the 50 least developed countries; less than one sixth goes to agriculture; even less is spent for the main areas of the social sector, i.e. education, primary health care and reproductive health. Of the allocation to education, only a small portion is spent on primary education. A larger share is allotted to the secondary and university levels serving the few.

Norway introduced the so-called '20/20' formula as one of the main objectives for the World Summit for Social Development in Copenhagen this spring. The underpinnings for the proposal have been developed jointly by UNDP, UNESCO, UNFPA, UNICEF and WHO. They have suggested an allocation of an average of 20% of the recipient governments' national budgets and 20% of the donor countries' aid budgets, to basic social services. I am convinced that an increased allocation to priority basic social programmes would substantially contribute to the objective of reaching the poorest.

A great many reports have been presented which have enhanced our understanding of pressing problems. We will continue to need a reminder that the common interest is more often than not also in our own best national interest – to live in a better organized, more just and equitable world. Enormous efforts have gone into United Nations work on development. We have adopted work programmes and plans of action – even priority programmes – but they have been acted on with a conspicuous lack of dynamism.

In an interdependent world, we must show solidarity across borders and generations. We need an equitable sharing of global bills for peace, environment and development. In this perspective Norway will continue to remind the world of the United Nations target of 0.7% of GNP for development aid purposes. This is a minimal taxation of the fortunate few for the benefit of the powerless poor.

The most commonly used measure of aid is official development assistance or ODA.

ODA means aid from governments for humanitarian and development purposes. Military aid is specifically excluded.

About two thirds of ODA is bilateral – given directly from one government to another. The remaining third is multilateral aid – channelled via international organizations and United Nations agencies.

In addition, aid from voluntary organizations in the rich world amounted to an estimated $6.3 billion in 1993.

ACHIEVEMENT AN

Aid programmes cut, only 4 reach 0.7% target

Almost all the industrialized nations have reduced their aid programmes, according to the latest figures from the OECD Development Assistance Committee (the donors' club of rich nations). Overall, total aid was down 8% from $61 billion in 1992 to $56 billion in 1993. Figures for 1994 are not yet available. The United States, the second biggest donor in absolute terms, has fallen to bottom place in the aid league table.

On average, the industrialized nations gave 0.3% of GNP in aid in 1993 – less than half the 0.7% target agreed to 25 years ago. Only four nations – Denmark, the Netherlands, Norway, and Sweden – met the 0.7% target in both 1992 and 1993.

Some of the steepest falls in aid have occurred in countries with the best long-term aid records. The amount given per person has been halved in Finland (from $141 in 1992 to $70 in 1993), and sharply reduced in Sweden ($270 to $203) and Norway ($288 to $236). But Danes still give three times as much in aid per person as Germans, Norwegians three times as much as Canadians, Dutch twice as much as Japanese, and Swedes five times as much as Americans.

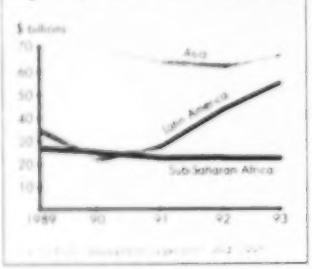
Aid provided by non-DAC members (mainly the Soviet Union and oil-rich Arab States) accounted for about a third of total aid in the late 1970s, but has since declined to about 3%. Many former aid donors in Eastern Europe and the Soviet Union have joined the list of recipients. Aid from Arab countries, approximately $1 billion in 1993, is at an all-time low.

Roughly a third of 1992 aid was tied to purchases of goods and services from the donor country. From the recipient's point of view, tied aid is usually less valuable (by about 15% according to some estimates) because it reduces the scope for competitive bidding and takes away the freedom to shop around.

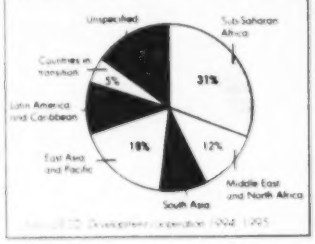
Africa loses out

Aid accounts for about a third of financial flows to the poor world. Counting bank lending, private investment, and export credits, total flows have increased sharply since 1989. But the world's poorest region has been bypassed.

Net resource flows to developing regions ($ billions in 1992 dollars)



Where the aid went in 1993



The aid record

Proportions

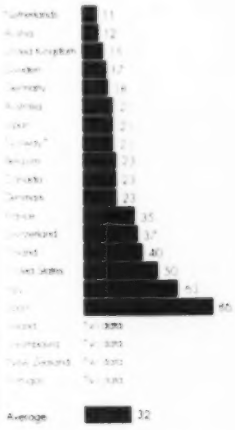
ODA as % of donor nations' GNP, 1993

Amounts

	Total aid given ($ billions) 1993	Aid given per person ($) 1993
[illegible]	[illegible]	[illegible]
Total	56.0	70

Restrictions

% of bilateral aid tied to purchases from donor country and partners, 1992



DISPARITY

Basic services like education and health get only 10% of aid and government spending

Doubling the investment in basics

The World Summit for Social Development, meeting in Copenhagen in March 1995, endorsed the idea of doubling the current rate of investment in basic social services – nutrition, primary health care, basic education, clean water, safe sanitation, and family planning.

The Summit, attended by a majority of the world's political leaders, agreed on a set of non-binding 'commitments' designed to end the worst aspects of world poverty. Among other recommendations, the Summit called for the 0.7% aid target to be met and for *"interested developed and developing country partners to allocate, on average, 20% of official development assistance and 20% of the national budget, respectively, to basic social programmes."*

Most estimates suggest that about 10% of aid and only a slightly higher proportion of developing country budgets are currently allocated to basic social services. The '20/20' proposal, if acted on, would therefore represent an approximate doubling of investment in social development.

Economic development, and the more equitable distribution of its benefits within and between nations, remain fundamental to ending world poverty. But a doubling of direct investment by governments in the meeting of basic human needs could, according to United Nations estimates, abolish the worst aspects of poverty from the planet within a decade.

Spanish lesson

For two months at the end of 1994, over 7,000 people camped outside government buildings in the Spanish capital to demand a rise in both the quantity and quality of Spanish aid.

The campaign slogan was *"0.7 now"*, a reference to the target aid figure of 0.7% of GNP accepted by the industrialized nations 25 years ago.

Supported by leading church figures, non-governmental organizations, trade unions and 25,000 demonstrating students in 30 cities, the campaign demanded more information on Spanish aid and a radical overhaul to switch aid from military purposes to basic human needs.

The Spanish Government, currently giving only 0.23% of GNP in aid and ranked 18th among the 21 donor countries, has hinted that it might increase aid to between 0.35% and 0.5% of GNP for 1995 and to the target figure of 0.7% by 1996.

Keeping aid in proportion

A 1993 poll found that Americans believe one fifth of government spending goes to foreign aid – more than 20 times the true figure. Canadians believe their aid budget is 5 times larger than it actually is. Many in the industrialized world also have an exaggerated view of the developing world's dependence on aid.

On average, government aid from rich nations now amounts to less than one third of 1% of GNP – or $70 a year from each person in the industrialized world. Put another way, the rich world spends more on wine than on aid for development.

As for the poor world's dependence, one obvious measure is the amount received as a proportion of the GNP of the developing countries. For the 50 poorest countries, aid received amounts to about 11% of GNP. But for all other developing nations, aid contributes an average of less than 1% of GNP.

Another measure of dependence is aid as a proportion of total government revenues. In Zambia, 70% of government revenue comes from foreign aid. In India, the proportion is about 4%.

The tables are based on data from a limited number of countries.

Aid and health

Aid for health as a percentage of government spending on health, 1990

Highest		Lowest	
Sub-Saharan Africa			
Mozambique	52.9	Zambia	4.9
Uganda	48.4	Côte d'Ivoire	3.4
Middle East and North Africa			
Sudan	13.0	Turkey	0.5
Jordan	12.4	Algeria	0.1
South Asia			
Nepal	23.6	Pakistan	5.4
Bangladesh	17.9	India	1.6
East Asia and Pacific			
Lao Rep	22.7	Malaysia	0.2
Viet Nam	15.9	Singapore	0.1
Latin America and Caribbean			
Bolivia	20.3	Argentina	0.2
Nicaragua	20.0	Venezuela	0.1

[illegible]

Aid dependence

Aid is vital to the functioning of government in some nations of the developing world – and relatively insignificant for others.

	Aid as % of all central government revenues		Aid as % of all central government revenues
Brazil	0*	Philippines	14
Dominican Rep	0*	Namibia	15
Korea, Rep	0*	Yemen	15
Singapore	0*	Guatemala	16
Venezuela	0*	Egypt	17
Argentina	1	Jordan	18
Iran	1	Zimbabwe	20
Malaysia	1	Sri Lanka	21
Mexico	1	Papua New Guinea	24
Trinidad/Tob	1	Côte d'Ivoire	26
Chile	2	Cameroon	27
Colombia	2	Lesotho	27
Oman	2	Zaire	30
Turkey	2	Kenya	34
Myanmar	3	El Salvador	35
Thailand	3	Ethiopia	37
Uruguay	3	Bolivia	38
India	4	Liberia	39
Panama	4	Ghana	40
Syria	4	Guinea	50
Botswana	5	Malawi	54
Costa Rica	5	Nepal	54
Mauritius	5	Nicaragua	55
Tunisia	5	Madagascar	57
Gabon	6	Bhutan	59
Indonesia	7	Rwanda	66
Morocco	7	Chad	67
Ecuador	9	Sierra Leone	69
Pakistan	11	Zambia	70
Paraguay	11	[illegible]	[illegible]
Peru	13	[illegible]	[illegible]

[illegible]

Aid and the top 20%

The table shows aid received compared with the incomes of the richest 20% of the people in the main aid-receiving countries.

	Aid received ($ millions) 1993	As % of income of richest 20%
China	3280	1
India	1533	1
Indonesia	2024	3
Pakistan	1067	5
Philippines	1485	6
Egypt	2256	13
Bangladesh	1359	14
Kenya	929	22
Ethiopia	1209	44
Tanzania	978	62
Mozambique	1155	–

SOCIAL INDICATORS

LESS POPULOUS COUNTRIES

The indicators used to construct the main league tables in *The Progress of Nations 1995* include: percentage of female representation in parliaments; percentage of populations with access to safe water; national performance gaps in primary education; and change in fertility rates 1963 to 1993.

Using these same indicators, the following table shows the progress of those countries with populations of less than 1 million. The regional standing of these less populous countries can be assessed by comparing the figures given here with the relevant league tables.

In the case of progress towards polio eradication and progress towards eliminating vitamin A deficiency (VAD), the numbers for each country refer to the different stages of progress as defined on page 4 (polio) and page 12 (vitamin A deficiency).

Basic social indicators are also provided – enabling comparisons to be made with the statistical profiles on pages 52 and 53.

	% MPs women	Progress on vitamin A	Progress on polio	Access to safe water 1989-93	Reaching grade 5 NPG	Change in total fertility rate 1963-93	Population (thousands) 1993 Total	Population (thousands) 1993 Under 16	Annual no. of births (thousands) 1993	Annual no. of under-5 deaths (thousands) 1993	Under-5 mortality rate 1993	GNP per capita ($) 1993	% of under-5 children under-weight 1976-90	% children reaching grade 5 1986-93	Total fertility rate 1993	Maternal mortality rate 1980-91
Antigua/Barbuda	6	No VAD	1	100	-	-	65	29	1	0.0	24	6390	10	-	1.9	-
Bahamas	8	No VAD	1	-	+8	-1.9	268	87	5	0.2	29	11500	-	100	2.0	69
Bahrain	-	No VAD	2	-	+9	-3.4	535	181	15	0.3	22	7870	-	99	3.7	34
Barbados	4	No VAD	1	100	-9	-2.3	260	66	4	0.0	10	6240	5	80	1.8	27
Belize	4	3	1	81	-15	-2.3	204	93	7	0.3	42	2440	-	69	4.1	19
British Virgin Islands	-	4	1	100	-	-	18	-	0	0.0	31	8500	-	-	-	-
Brunei Darussalam	-	No VAD	2	-	+5	-3.6	274	101	7	0.1	10	20760	-	100	3.0	-
Cape Verde	8	No VAD	2	52	-10	-2.8	370	167	14	1.0	73	870	19	60	4.2	110
Comoros	2	4	2	69	-1	0.1	607	308	30	3.8	128	520	-	58	7.0	500
Cook Islands	-	No VAD	2	100	-	-	19	-	0	0.0	28	1550	-	-	-	46
Cyprus	5	No VAD	2	-	-10	-0.9	726	201	14	0.1	10	10380	-	82	2.5	-
Djibouti	0	1	3	84	-33	-1.1	557	248	21	3.3	158	780	23	35	5.8	740
Dominica	13	4	1	96	+9	-	71	26	2	0.0	22	2680	4	93	2.5	58
Equatorial Guinea	9	No VAD	3	35	-	0.3	379	171	17	3.1	180	360	-	-	5.9	430
Fiji	4	No VAD	2	56	+4	-2.9	758	292	18	0.5	28	2140	-	87	3.0	90
Gambia	8	2	3	77	+16	-0.9	1042	453	45	9.7	216	360	-	67	5.6	1050
Grenada	13	No VAD	1	85	-	-	92	34	2	0.1	35	2410	-	-	2.9	100
Guyana	20	4	1	40	+47	-3.6	816	283	20	1.3	63	350	22	97	2.5	200
Iceland	24	No VAD	2	-	-	-1.6	263	69	5	0.0	6	23620	-	-	2.2	0
Kiribati	0	1	2	73	+17	-	76	31	3	0.2	80	710	-	83	4.1	10
Luxembourg	20	No VAD	2	-	+1	-0.7	395	72	5	0.1	10	35850	-	99	1.7	0
Maldives	4	4	2	95	-	-0.3	238	117	10	0.8	78	820	-	-	6.7	400
Malta	2	4	2	-	+10	-1.0	361	87	5	0.1	12	7280	-	100	2.1	0
Marshall Islands	3	2	1	74	-	-	50	-	2	0.2	92	*	-	-	-	110
Micronesia, Fed. States	0	2	2	30	-	-	118	49	4	0.1	29	980	-	-	4.5	83
Montserrat	-	4	1	45	-	-	11	4	0	0.0	15	3330	-	-	2.2	-
Palau	-	No VAD	2	88	-	-	16	-	0	0.0	35	790	-	-	-	-
Qatar	-	4	2	-	-10	-2.7	529	153	11	0.3	25	15140	-	84	4.3	9
Saint Kitts/Nevis	6	No VAD	1	100	+1	-	42	12	1	0.0	41	4470	-	88	2.5	150
Saint Lucia	0	No VAD	1	100	+11	-	139	63	4	0.1	22	3040	14	96	3.0	26
Saint Vincent/Grenadines	13	No VAD	1	89	-	-	110	37	2	0.1	24	2130	-	-	2.5	13
Samoa	4	No VAD	2	70	-	-4.0	167	83	6	0.3	57	940	-	-	4.5	400
Sao Tome/Principe	11	No VAD	2	-	+39	-	127	51	5	0.4	84	330	17	88	4.9	79
Seychelles	27	4	2	-	+8	-	72	24	2	0.0	20	6370	6	97	2.7	60
Solomon Islands	2	2	2	61	+17	-1.1	354	167	13	0.4	33	750	-	84	5.3	550
Suriname	6	4	1	-	+22	-3.8	414	153	10	0.3	34	1210	-	99	2.7	89
Swaziland	3	4	2	-	+3	-1.7	809	374	31	3.3	107	1050	10	77	4.8	110
Tonga	3	No VAD	2	94	+2	-	98	39	3	0.1	25	1610	-	84	3.8	37
Turks/Caicos Islands	-	4	1	85	-	-	13	-	0	0.0	31	780	-	-	-	-
Tuvalu	8	No VAD	2	90	+5	-	9	-	-	-	56	650	-	69	-	190
Vanuatu	2	No VAD	2	79	-16	-2.3	161	74	6	0.3	58	1230	20	61	4.6	110

* GNP estimated range $696 – $2785

NATIONAL PERFORMANCE GAPS

The following tables provide additional statistical information on the progress of nations.

Pages 50 and 51 show the national performance gaps, for all countries, in child survival, child nutrition, and primary education. The national performance gap is the difference between the actual level of progress achieved and the expected level of progress for each country's per capita GNP.

Pages 52 and 53 present a basic social profile of each nation, and list the social development goals that have been adopted for 1995 and the year 2000.

NATIONAL PERFO

The tables on these pages show each country's national performance gap in the areas of child survival, nutrition, and education.

The national performance gap is the difference between a country's actual level of progress and the expected level for its per capita GNP.

For each indicator, the expected level of achievement has been calculated from the per capita GNPs and the relevant social indicators of all countries (see panel opposite). The expected level therefore represents the level that the average-performing country could be expected to have reached for its level of GNP per capita.

	GNP per capita $ 1993	Under-five mortality rate 1993			% of children reaching grade 5			% of under-five children underweight		
		Actual	Expected	Difference	Actual	Expected	Difference	Actual	Expected	Difference
SUB-SAHARAN AFRICA										
Angola	[illegible]			-	[illegible]		-31			-
Benin	[illegible]			-	[illegible]		-5			-
Botswana	[illegible]	[illegible]	[illegible]	-23	[illegible]	[illegible]	0			-2
Burkina Faso	[illegible]	[illegible]	[illegible]	-34	[illegible]	[illegible]	-21			+1
Burundi	[illegible]	[illegible]	[illegible]	-3	[illegible]	[illegible]	+17			-2
Cameroon	[illegible]	[illegible]	[illegible]	-34	[illegible]	[illegible]	-1			+5
Central African Rep.	[illegible]	[illegible]	[illegible]	-54	[illegible]	[illegible]	-10			-
Chad	[illegible]			-			-1			-
Congo	[illegible]			-	[illegible]	[illegible]	+1			-7
Côte d'Ivoire	[illegible]			-	[illegible]	[illegible]	-9			+7
Ethiopia	[illegible]	[illegible]		+3			-			-
Gambia	[illegible]	[illegible]		+9	[illegible]	[illegible]	-15	[illegible]	[illegible]	-5
Ghana	[illegible]			-			-37			-
Guinea	[illegible]		[illegible]	-52			+17			0
Kenya	[illegible]			-	[illegible]	[illegible]	-32			-
Lesotho	[illegible]			-			-20			+15
Madagascar	[illegible]	[illegible]	[illegible]	+58			+32			+10
Malawi	[illegible]			-	[illegible]	[illegible]	-17			+15
Mali	[illegible]	[illegible]	[illegible]	-103			-			-
Mauritania	[illegible]	[illegible]	[illegible]	-8			-20	[illegible]	[illegible]	-6
Mozambique	[illegible]	[illegible]	[illegible]	-61			-13			+7
Niger	[illegible]	[illegible]	[illegible]	-76			-25			-1
Nigeria	[illegible]	[illegible]	[illegible]	-96			+5	[illegible]		-24
Rwanda	[illegible]	[illegible]		+9			+10			-10
Senegal	[illegible]			-			+4			-
Sierra Leone	[illegible]	[illegible]		-42			-18			-11
Somalia	[illegible]	[illegible]	[illegible]	-172			-22			-5
Sudan	[illegible]	[illegible]	[illegible]	-52			+8			-5
Tanzania	[illegible]	[illegible]	[illegible]	27			+22			+4
Togo	[illegible]	[illegible]	[illegible]	-37			-15			+1
Uganda	[illegible]	[illegible]	[illegible]	-93			-			+8
Zaire	[illegible]	[illegible]		-			-			-
Zambia	[illegible]	[illegible]		-						-
South Africa	[illegible]	[illegible]	[illegible]	-37			-14			-
Tanzania	[illegible]	[illegible]	[illegible]	+46	[illegible]	[illegible]	0	[illegible]	[illegible]	+14
Togo	[illegible]	[illegible]	[illegible]	0	[illegible]	[illegible]	+21	[illegible]	[illegible]	+2
Uganda	[illegible]	[illegible]	[illegible]	-14	[illegible]	[illegible]	0	[illegible]	[illegible]	+15
Zaire	[illegible]	[illegible]	[illegible]	-29	[illegible]	[illegible]	+9			-
Zambia	[illegible]	[illegible]	[illegible]	-76	[illegible]	[illegible]	+15	[illegible]	[illegible]	+6
Zimbabwe	[illegible]	[illegible]	[illegible]	+19	[illegible]	[illegible]	+16	[illegible]	[illegible]	+11
MIDDLE EAST and NORTH AFRICA										
Algeria	1650	68	37	-31	[illegible]	[illegible]	+11	[illegible]	[illegible]	+5
Egypt	660	59	89	+30	[illegible]	[illegible]	+29	[illegible]	[illegible]	+14
Iran	2200	54	34	-20	[illegible]	[illegible]	+6			
Iraq	1500	71	38	-33	[illegible]	[illegible]	-15	[illegible]	[illegible]	+3
Jordan	1190	27	50	+23	[illegible]	[illegible]	+21	[illegible]	[illegible]	+9
Kuwait	23350	13	11	-2	[illegible]	[illegible]	-13	[illegible]		-3
Lebanon	2150	40	35	-5			-			
Libya	5310			-			-			
Morocco	1030	59	60	+1	[illegible]	[illegible]	+2	[illegible]	[illegible]	+9
Oman	5600	29	25	-4	[illegible]	[illegible]	-3			
Saudi Arabia	7510	38	22	-16	[illegible]	[illegible]	-19			
Sudan	420	129	119	-9	[illegible]	[illegible]	+2			+7
Syria	1160	39	52	+13	[illegible]	[illegible]	+15			
Tunisia	1780	36	36	0	[illegible]	[illegible]	+8			+5
Turkey	2120	60	35	-25	[illegible]	[illegible]	+6			+2
U. Arab Emirates	22470	21	11	-10	[illegible]	[illegible]	+3			
Yemen	520	137	105	-32	[illegible]	[illegible]	+7			-5
SOUTH ASIA										
Afghanistan	280			-	[illegible]	[illegible]	-33			-
Bangladesh	220	[illegible]	[illegible]	+40	[illegible]	[illegible]	+7	[illegible]		-31
Bhutan	[illegible]	[illegible]	[illegible]	-19	[illegible]	[illegible]	-26	[illegible]	[illegible]	-1
India	280	122	143	+21	[illegible]	[illegible]	+16	[illegible]		-38
Nepal	160	128	182	+54	[illegible]	[illegible]	+18			-
Pakistan	430	[illegible]	[illegible]	-19	[illegible]	[illegible]	-18	[illegible]	[illegible]	-13
Sri Lanka	600	19	95	+76	[illegible]	[illegible]	+30	[illegible]	[illegible]	-15
EAST ASIA and PACIFIC										
Cambodia	[illegible]			-			-	[illegible]	[illegible]	-4
China	[illegible]	[illegible]	[illegible]	+66	[illegible]	[illegible]	+30	[illegible]	[illegible]	+14
Hong Kong	17660	[illegible]	[illegible]	+7	[illegible]	[illegible]	+5			-
Indonesia	[illegible]	[illegible]	[illegible]	-28	[illegible]	[illegible]	+20	[illegible]	[illegible]	-15
Korea, Dem.	[illegible]	[illegible]	[illegible]	+32			-			-
Korea, Rep.	[illegible]	[illegible]	[illegible]	+13	[illegible]	[illegible]	+3			-
Lao PDR	[illegible]	[illegible]	[illegible]	+2	[illegible]	[illegible]	+5	[illegible]	[illegible]	-3
Malaysia	[illegible]	[illegible]	[illegible]	+14	[illegible]	[illegible]	+7	[illegible]	[illegible]	-13
Mongolia	[illegible]	[illegible]	[illegible]	+44			-	[illegible]	[illegible]	+9
Myanmar	[illegible]	[illegible]	[illegible]	+51			-	[illegible]	[illegible]	+2
Papua New Guinea	[illegible]			-	[illegible]	[illegible]	-9	[illegible]	[illegible]	-16
Philippines	[illegible]	[illegible]	[illegible]	+15	[illegible]	[illegible]	+6	[illegible]		-13
Singapore	[illegible]	[illegible]	[illegible]	+7	[illegible]	[illegible]	+5			-

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	GNP per capita $ 1993	Under-five mortality rate 1993			% of children reaching grade 5			% of under-five children underweight		
		Actual	Expected	Difference	Actual	Expected	Difference	Actual	Expected	Difference
Thailand	2540	33	35	**+2**	88	83	**+5**	26	17	**-9**
Vietnam	170	48	178	**+130**	9	15	**+23**	42	33	**-9**
LATIN AMERICA and CARIBBEAN										
Argentina	7290	27	22	**-5**			**-**			**-**
Bolivia	1170	104	69	**-35**		67	**-7**	16	21	**+5**
Brazil	3020	63	31	**-32**		43	**-29**		11	**+3**
Chile	3370	17	31	**+14**		53	**+8**	3	13	**+10**
Colombia	1400	37	58	**+21**		80	**-21**	10	16	**+6**
Costa Rica	2190	17	35	**+18**	80	83	**+3**	5	14	**+9**
Cuba	-	12	54	**+42**	96	76	**+19**			**-**
Dominican Rep	1430	48	39	**+9**	71	71	**-34**	10	19	**+9**
Ecuador	1330	47	42	**-5**	74	76	**-9**	17	15	**+2**
El Salvador	1190	50	33	**-17**	71	92	**-21**	11	8	**+3**
Guatemala	1100	91	73	**-18**	55	89	**-34**	24	9	**-15**
Haiti	250	125	122	**-3**	37	77	**-40**	27	26	**+1**
Honduras	1120	80	38	**+42**	61	81	**-20**	17	14	**+3**
Jamaica	1400	32	5	**+27**	90	74	**+16**	7	16	**+9**
Mexico	3320	42	39	**-3**	84	86	**-2**	4	8	**-4**
Nicaragua	1000	57	0	**+57**	63	59	**+4**	11	22	**+11**
Paraguay	1840	53	40	**+13**	79	84	**-2**	15	11	**-4**
Peru	1930	58	54	**+4**	81	87	**-7**	4	16	**+12**
Peru	2490	85	61	**-24**			**-**	7	15	**+8**
Trinidad & Tobago	3700	17	9	**+8**	93	86	**-17**	3	4	**+1**
Venezuela	3470	37	29	**+8**	82	73	**+9**	7	10	**+3**
Venezuela	3440	31	23	**+8**	74	81	**-7**	5	11	**+5**
INDUSTRIALIZED COUNTRIES										
Australia	15510	8	14	**+6**			**-**			**-**
Austria	22120	8	11	**+3**			**-**			**-**
Belgium	17700	9	11	**+2**			**-**			**-**
Canada	19570	8	12	**+4**			**-**			**-**
Denmark	22550	7	10	**+3**			**-**			**-**
Finland	18470	5	13	**+8**			**-**			**-**
France	22160	8	10	**+2**			**-**			**-**
Germany	21550	7	11	**+4**			**-**			**-**
Greece	7190	10	22	**+12**			**-**			**-**
Ireland	13180	9	19	**+10**			**-**			**-**
Israel	11760	9	16	**+7**			**-**			**-**
Italy	19620	9	13	**+4**			**-**			**-**
Japan	21450	6	8	**+2**			**-**			**-**
Netherlands	20710	8	12	**+4**			**-**			**-**
New Zealand	12900	9	17	**+8**			**-**			**-**
Norway	25340	8	10	**+2**			**-**			**-**
Portugal	7890	11	22	**+11**			**-**			**-**
Spain	13550	9	16	**+7**			**-**			**-**
Sweden	24930	6	10	**+4**			**-**			**-**
Switzerland	36410	6	5	**-1**			**-**			**-**
United Kingdom	19770	8	13	**+5**			**-**			**-**
United States	24750	10	10	**0**			**-**			**-**
COUNTRIES IN TRANSITION										
Albania	340	41	133	**+92**			**-**			**-**
Armenia	660	33	89	**+56**			**-**			**-**
Azerbaijan	730	52	83	**+31**			**-**			**-**
Belarus	2840	22	32	**+10**	89	85	**+14**			**-**
Bosnia Herzegovina	*			**-**			**-**			**-**
Bulgaria	1160	19	52	**+33**	78	76	**+2**			**-**
Croatia	**			**-**			**-**			**-**
Czech Rep	2730	10	32	**+22**	95	84	**+11**			**-**
Estonia	3140	23	31	**+8**	78	85	**-7**			**-**
Georgia	550	28	100	**+72**			**-**			**-**
Hungary	3330	15	30	**+15**	97	85	**+12**			**-**
Kazakhstan	1540	49	38	**-11**			**-**			**-**
Kyrgyzstan	830	58	74	**+16**			**-**			**-**
Latvia	2330	26	35	**+9**			**-**			**-**
Lithuania	1310	20	44	**+24**	93	79	**+14**			**-**
Macedonia	790	33	78	**+45**	45	68	**+18**			**-**
Moldova	840	36	51	**+15**			**-**			**-**
Poland	2270	15	34	**+19**	94	83	**+11**			**-**
Romania	1120	29	54	**+25**	91	75	**+16**			**-**
Russian Fed	2350	31	34	**+3**			**-**			**-**
Slovakia	1920	18	36	**+18**	97	83	**+14**			**-**
Slovenia	3110	10	24	**+14**	100	89	**+11**			**-**
Tajikistan	470	83	112	**+29**			**-**			**-**
Turkmenistan	720	89	48	**-41**			**-**			**-**
Ukraine	1910	25	36	**+11**			**-**			**-**
Uzbekistan	960	56	54	**-2**			**-**			**-**
Yugoslavia	**			**-**			**-**			**-**

* GNP estimated range $645 or less

** GNP estimated range $646 - $2785

NATIONAL PERFORMANCE GAPS – DERIVING THE EXPECTED

For each of the three indicators used in these tables, deriving an expected level of performance requires the fitting of a line to country data represented by points on a graph of which one axis is always GNP per capita.

When all countries with data are plotted, the pattern that emerges shows that under-five mortality rates and malnutrition rates generally decrease with increasing GNP, whereas the percentage of children reaching grade 5 generally increases with GNP. For each variable, a line was fitted to match the overall shape of the data points, using a least-squares regression method. GNP data for 1993 were used in plotting the graphs except in the case of underweight children, where the data were matched with GNP data for the same reference year.

The adjusted R-squared for the lines thus drawn varied from a little more than 0.4 in the case of the percentage of children underweight to a little over 0.7 for the under-five mortality rate. Such values show that while there is a general trend linking each variable with GNP, many individual countries diverge considerably from this trend.

It is this lack of conformity with the trend line – the expected level of performance – which yields the national performance gaps for each country. The tables on these pages show national performance gaps in bold type.

NPGs in primary education are not given for industrialized countries as the differences are not significant for countries in which 95% or more reach grade 5 of primary school.

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This edition of The Progress of Nations records advances and set-backs in the struggle to reach the social development goals that were adopted by a majority of the world's nations at the 1990 World Summit for Children.

The overall goals, to be achieved by the end of the century, are summarized in the right-hand column.

Governments also accepted a series of intermediate or stepping-stone goals to be achieved by the end of 1995. These are set out below.

The main goals for 1995 are:

1 The raising of immunization coverage to at least 80%.

2 The elimination of neonatal tetanus.

3 A major reduction in measles deaths and cases.

4 The eradication of polio.

5 The achievement of 80% ORT use to combat diarrhoeal disease.

6 Support for breastfeeding through the baby-friendly hospital initiative and the ending of free and low-cost distribution of breastmilk substitutes.

7 The virtual elimination of vitamin A deficiency.

8 The universal iodization of salt.

9 The virtual elimination of guinea worm disease.

10 The universal ratification of the Convention on the Rights of the Child.

STATISTICAL PRO

	Total population (millions) 1993	Population under 16 (millions) 1993	Annual no. of births (thousands) 1993	Annual no. of under-5 deaths (thousands) 1993	Under-5 mortality rate 1993	GNP per capita ($) 1993	% of under-5 children under-weight	% of children reaching grade 5	Total fertility rate 1993	Maternal mortality rate
SUB-SAHARAN AFRICA										
Angola	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		[illegible]	[illegible]	
Benin	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		[illegible]	[illegible]	[illegible]
Botswana	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		[illegible]	[illegible]	[illegible]
Burkina Faso	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		[illegible]	[illegible]	[illegible]
Burundi	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	
Cameroon	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Central African Rep.	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		[illegible]	[illegible]	[illegible]
Chad	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]			[illegible]	[illegible]
Congo	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Côte d'Ivoire	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		[illegible]	[illegible]	[illegible]
Ethiopia	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]			[illegible]	[illegible]
Gabon	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]			[illegible]	[illegible]
Gambia	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]			[illegible]	[illegible]
Ghana	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]			[illegible]	[illegible]
Guinea	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]			[illegible]	[illegible]
Guinea-Bissau	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]			[illegible]	[illegible]
Kenya	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]			[illegible]	[illegible]
Lesotho	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]			[illegible]	[illegible]
Liberia	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]			[illegible]	[illegible]
Madagascar	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]			[illegible]	[illegible]
Malawi	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]			[illegible]	[illegible]
Mali	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]			[illegible]	[illegible]
Mauritania	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		[illegible]	
Mauritius	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]			[illegible]
Mozambique	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]			[illegible]	[illegible]
Namibia	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		[illegible]	[illegible]	[illegible]
Niger	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]			[illegible]	[illegible]
Nigeria	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]			[illegible]	[illegible]
Rwanda	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]			[illegible]	[illegible]
Senegal	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]			[illegible]	[illegible]
Sierra Leone	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]			[illegible]	[illegible]
Somalia	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]			[illegible]	[illegible]
South Africa	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]			[illegible]	[illegible]
Swaziland	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Togo	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Uganda	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Zaire	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Zambia	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Zimbabwe	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	–
MIDDLE EAST and NORTH AFRICA										
Algeria	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Egypt	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Iran	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		[illegible]	[illegible]	[illegible]
Iraq	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Jordan	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Kuwait	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Lebanon	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		[illegible]	[illegible]	
Libya	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]			[illegible]	
Morocco	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Oman	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		[illegible]	[illegible]	
Saudi Arabia	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		[illegible]	[illegible]	[illegible]
Sudan	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Syria	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		[illegible]	[illegible]	[illegible]
Tunisia	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		[illegible]	[illegible]	[illegible]
Turkey	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		[illegible]	[illegible]	[illegible]
U. Arab Emirates	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		[illegible]	[illegible]	–
Yemen	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	–
SOUTH ASIA										
Afghanistan	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		[illegible]	[illegible]	[illegible]
Bangladesh	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Bhutan	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
India	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Nepal	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		[illegible]	[illegible]	[illegible]
Pakistan	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Sri Lanka	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
EAST ASIA and PACIFIC										
Cambodia	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		[illegible]	[illegible]
China	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		[illegible]	[illegible]	[illegible]
Hong Kong	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		[illegible]	[illegible]	[illegible]
Indonesia	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Korea, Dem.	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]			[illegible]	[illegible]
Korea, Rep.	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		[illegible]	[illegible]	[illegible]
Lao Rep.	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Malaysia	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Mongolia	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]			[illegible]	[illegible]
Myanmar	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		[illegible]	[illegible]	[illegible]
Papua New Guinea	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]			[illegible]	[illegible]
Philippines	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Singapore	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

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	Total population (millions) 1993	Population under 16 (millions) 1993	Annual no. of births (thousands) 1993	Annual no. of under-5 deaths (thousands) 1993	Under-5 mortality rate 1993	GNP per capita ($) 1993	% of under-5 children under-weight	% of children reaching grade 5	Total fertility rate 1993	Maternal mortality rate
Thailand	57.6	18.2	1091	36	33	2040	26	88	2.1	50
Viet Nam	71.3	28.7	2186	104	48	170	52	58	3.8	120
LATIN AMERICA and CARIBBEAN										
Argentina	33.8	10.6	683	18	27	7290	–	–	2.8	140
Bolivia	7.3	3.0	252	29	114	770	16	60	4.8	600
Brazil	156.5	35.1	3924	241	63	3020	7	56	2.9	200
Chile	13.8	4.4	300	5	17	6070	3	93	2.5	35
Colombia	34.0	12.3	809	15	19	1400	10	59	2.7	200
Costa Rica	3.3	1.2	85	[illegible]	16	2160	6	86	3.1	36
Cuba	10.9	2.6	183	2	10	1170	–	95	1.8	19
Dominican Rep.	7.8	2.9	201	[illegible]	38	1180	10	41	3.1	–
Ecuador	11.0	4.4	308	17	57	1170	17	67	3.5	170
El Salvador	5.5	2.4	145	11	60	1320	15	58	4.0	–
Guatemala	10.0	4.7	347	28	73	1110	34	41	5.3	200
Haiti	6.4	2.9	243	32	130	370	27	12	4.8	600
Honduras	5.3	2.5	197	11	56	580	21	41	4.9	220
Jamaica	2.4	0.8	52	1	13	1390	7	96	2.3	120
Mexico	90.0	35.1	2478	80	32	3750	14	84	3.2	110
Nicaragua	4.1	2.0	165	12	72	360	11	55	5.0	–
Panama	2.5	0.9	63	1	20	2580	16	82	2.9	60
Paraguay	4.7	2.0	154	5	34	1200	4	74	4.3	300
Peru	22.9	8.8	523	28	52	1490	11	76	3.4	300
Trinidad/Tobago	1.3	0.5	26	1	21	3730	7	69	2.4	110
Uruguay	3.1	0.8	54	1	21	3910	7	95	2.3	36
Venezuela	20.9	8.2	567	13	24	2840	6	78	3.3	–
INDUSTRIALIZED COUNTRIES										
Australia	17.6	4.1	260	2	8	17510	–	99	1.9	3
Austria	7.9	1.5	94	1	8	23120	–	97	1.5	8
Belgium	10.0	1.9	122	1	10	21210	–	–	1.6	3
Canada	28.8	6.4	436	4	8	20670	–	96	1.9	5
Denmark	5.2	0.9	65	0	7	26510	–	97	1.7	3
Finland	5.1	1.0	67	0	5	18970	–	100	1.9	11
France	57.5	12.2	738	7	9	22360	–	94	1.7	9
Germany	80.9	13.9	786	6	7	23560	–	95	1.3	5
Greece	10.4	2.0	102	1	10	7390	–	93	1.4	5
Ireland	3.5	1.0	51	0	7	12580	–	96	2.1	2
Israel	5.3	1.7	110	1	9	13760	–	96	2.9	3
Italy	57.1	9.6	558	5	9	19620	–	95	1.3	4
Japan	124.5	22.9	1246	8	6	31450	–	100	1.5	11
Netherlands	15.3	3.0	199	2	8	20710	–	95	1.6	10
New Zealand	3.5	0.9	61	1	9	12900	–	94	2.2	13
Norway	4.3	0.9	62	0	8	26340	–	98	1.9	3
Portugal	9.8	2.1	119	1	11	7890	–	–	1.6	10
Spain	39.5	7.6	377	4	9	13650	–	96	1.2	5
Sweden	8.7	1.7	124	1	6	24830	–	98	2.1	5
Switzerland	7.1	1.3	90	1	8	36410	–	95	1.6	5
United Kingdom	57.9	11.9	779	6	8	17970	–	–	1.8	8
United States	257.9	60.1	4104	42	10	24750	–	94	2.1	8
COUNTRIES in TRANSITION										
Albania	3.4	1.1	80	3	41	340	–	–	2.8	–
Armenia	3.5	1.1	71	2	33	660	–	–	2.6	–
Azerbaijan	7.4	2.5	162	8	52	730	–	–	2.5	–
Belarus	10.2	2.4	117	3	22	2840	–	99	1.7	–
Bosnia/Herzegovina	4.7	0.9	50	1	15	*	–	–	1.6	–
Bulgaria	8.9	1.8	89	2	19	1160	–	78	1.5	9
Croatia	4.5	1.0	50	1	11	**	–	79	1.7	–
Czech Rep.	10.3	2.2	133	1	10	2730	–	95	1.8	–
Estonia	1.6	0.4	16	0	23	3040	–	78	1.6	–
Georgia	5.4	1.4	85	2	28	560	–	–	2.1	–
Hungary	10.2	2.1	119	2	15	3330	–	97	1.7	15
Kazakhstan	17.0	5.5	326	16	49	1540	–	–	2.5	–
Kyrgyzstan	4.6	1.8	131	8	58	830	–	–	3.7	–
Latvia	2.6	0.6	28	1	26	2030	–	–	1.6	–
Lithuania	3.7	0.9	49	1	20	1310	–	93	1.8	–
Macedonia	2.1	0.6	32	1	33	780	–	86	2.0	–
Moldova	4.4	1.3	67	2	36	1180	–	–	2.1	–
Poland	38.3	9.8	492	8	15	2270	–	94	1.9	11
Romania	23.0	5.4	245	7	29	1120	–	91	1.5	72
Russian Fed.	147.8	34.7	1498	46	31	2350	–	–	1.5	–
Slovakia	5.3	1.4	75	1	18	1900	–	97	1.9	–
Slovenia	1.9	0.4	20	0	10	6310	–	100	1.5	–
Tajikistan	5.8	2.6	210	17	83	470	–	–	4.9	–
Turkmenistan	3.9	1.7	124	11	89	1230	–	–	4.0	–
Ukraine	51.6	11.4	570	14	25	1910	–	–	1.6	–
Uzbekistan	21.9	9.3	678	45	66	960	–	–	3.9	–
Yugoslavia	10.6	2.6	148	–	–	**	–	–	2.0	–

* GNP estimated range $695 or less. ** GNP estimated range $696–$2785

The end-of-century social development goals agreed to by almost all the world's governments are summarized here under 10 priority points:

1 A one-third reduction in under-five death rates.

2 A halving of maternal mortality rates.

3 A halving of severe and moderate malnutrition among the world's under-fives, the elimination of micronutrient disorders, support for breast-feeding by all hospitals and maternity units, and a reduction in the incidence of low birth weight to less than 10%.

4 Achievement and maintenance of at least 90% immunization coverage for infants, and universal tetanus immunization for women in the child-bearing years; the eradication of polio, the elimination of neonatal tetanus, a 90% reduction in measles cases, and a 95% reduction in measles deaths (compared to levels before immunization).

5 Achievement of 80% ORT use and a halving of child deaths caused by diarrhoea.

6 A one-third reduction in child deaths from acute respiratory infections.

7 Basic education for all children and completion of primary education by at least 80% – girls as well as boys.

8 Safe water and sanitation for all families.

9 Acceptance and observance, in all countries, of the Convention on the Rights of the Child.

10 Family planning education and services to be made available to all.

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Age of data

The table below gives the average age of the latest internationally available data for three key social indicators – the under-five mortality rate, the percentage of children who reach grade 5, and the percentage of children who are malnourished.

The more up-to-date statistics used by most governments and all international organizations are often interpolated and/or extrapolated from past surveys. The table shows the number of years that have elapsed, on average, between the last national on-the-ground surveys and the year 1995.

In some cases, governments may have more recent statistics that have not yet been made available to the United Nations.

The average age of data has recently been sharply reduced in the 47 countries with published DHS surveys. (See box this page.)

A small number of countries have no known data at all under certain headings. Published data for such countries usually represent estimates based on neighbouring countries at similar levels of GNP per capita.

Average age of data (in years) on three social indicators

SUB-SAHARAN AFRICA					
Liberia	14.0	Congo	9.3	Mauritius	5.0
Somalia	12.7	Côte d'Ivoire	9.3	Zambia	5.0
Guinea-Bissau	12.3	South Africa	9.3	Malawi	4.7
Chad	12.0	Mali	7.7	Niger	4.7
Gabon	12.0	Ethiopia	7.0	Tanzania	4.7
Angola	11.7	Ghana	7.0	Mauritania	4.3
Benin	11.3	Togo	7.0	Namibia	4.0
Central African Rep.	11.3	Uganda	7.0	Rwanda	4.0
Guinea	11.3	Botswana	6.7	Senegal	3.7
Zaire	11.3	Burundi	6.0	Burkina Faso	3.3
Mozambique	10.7	Zimbabwe	6.0	Kenya	3.3
Sierra Leone	10.7	Nigeria	5.3	Madagascar	3.3
Lesotho	10.3	Cameroon	5.0	Eritrea	–
MIDDLE EAST and NORTH AFRICA					
Libya	15.0*	Syria	8.0	Iraq	4.3
Lebanon	12.3	Kuwait	6.3	Jordan	4.3
Iran	9.7	Sudan	6.3	Morocco	3.7
Saudi Arabia	9.3	Tunisia	5.7	Egypt	3.3
United Arab Emirates	9.0	Algeria	5.3	Turkey	3.0
Oman	8.3	Yemen	4.7		
SOUTH ASIA					
Afghanistan	12.0	Pakistan	5.3	Sri Lanka	4.0
Nepal	9.7	Bangladesh	5.0		
Bhutan	8.0	India	5.0		
EAST ASIA and PACIFIC					
Korea, Dem.	12.7	Hong Kong	8.3	Viet Nam	6.3
Cambodia	10.3	Lao Rep.	8.0	Philippines	6.0
Papua New Guinea	9.7	Mongolia	8.0	Indonesia	5.7
Korea, Rep.	9.3	Singapore	8.0	China	4.3
Myanmar	8.7	Thailand	6.7	Malaysia	3.7
LATIN AMERICA and CARIBBEAN					
Argentina	11.7	Mexico	6.7	Uruguay	4.7
Nicaragua	9.0	Cuba	6.3	Bolivia	3.0
Panama	8.3	Costa Rica	6.0		
Ecuador	7.7	Jamaica	6.0		
Honduras	7.3	Peru	6.0		
Guatemala	7.0	Chile	5.0		
Trinidad/Tobago	7.0	Colombia	5.0		
Brazil	6.7	Paraguay	5.0		
El Salvador	6.7	Venezuela	5.0		
Haiti	6.7	Dominican Rep.	4.7		

* Data with an average age of 5 years or more

Dates of DHS surveys

The DHS surveys drawn upon for pages 26-27 and 42-43 of *The Progress of Nations 1995* have been undertaken in a total of 47 countries over the last decade. The dates of each country survey are given below.

The DHS programme is funded by the United States Agency for International Development (USAID) and administered by Macro International, Inc., Maryland, USA.

1985	*El Salvador*
1986	*Brazil, Liberia*
1987	*Burundi, Ecuador, Guatemala, Mali, Mexico, Sri Lanka, Thailand, Trinidad/Tobago*
1988	*Botswana, Ghana, Togo, Tunisia, Uganda (1988/89), Zimbabwe (1988/89)*
1989	*Sudan (1989/90)*
1990	*Colombia, Jordan, Nigeria, Pakistan (1990/91), Paraguay*
1991	*Cameroon, Dominican Rep., Indonesia, Peru (1991/92), Tanzania (1991/92), Yemen (1991/92)*
1992	*Egypt, Madagascar, Malawi, Morocco, Namibia, Niger, Rwanda, Senegal (1992/93), Zambia*
1993	*Bangladesh (1993/94), Burkina Faso, Kenya, Philippines, Turkey*
1994	*Bolivia*

Abbreviations

ACC/SCN	United Nations Administrative Committee on Coordination/Subcommittee on Nutrition
AIDS	acquired immunodeficiency syndrome
CNN	Cable News Network
DHS	Demographic and Health Surveys
GNP	gross national product
HIV	human immunodeficiency virus
ICFTU	International Confederation of Free Trade Unions
ILO	International Labour Organisation
IQ	intelligence quotient
IUD	intra-uterine device
MP	Member of Parliament
NGO	non-governmental organization
NPG	national performance gap
OECD	Organisation for Economic Cooperation and Development
ORT	oral rehydration therapy
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
VAD	vitamin A deficiency
WHO	World Health Organization

Frontispiece photos by:
Jørgen Schytte (pages 2, 10, 18,); Laura Samsom Rous (pages 22, 28, 44); Peter Williams (page 36); Susi Lindig (girl representing countries in transition).

The Progress of Nations 1995 was produced for UNICEF by:
P&LA, 18 Observatory Close, Benson, Wallingford, Oxon OX10 6NU, UK.

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ISBN 92-806-3470-5 Sales No. E.95.XX.EKD.1 00695

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